FINAL PROPOSED RULE # 26-P020

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, General Provisions and Definitions (Part 1)

/s/ Dawn O'Toole , on 10/07/26

(signature) (date)

Printed Name and Title:
Dawn O'Toole, Chief Operations Officer, 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

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: Sarah Copeland Hanzas, Secretary of State

FROM: Jenney Samuelson, Secretary, Agency of Human Services

DATE: June 29, 2026

SUBJECT: Signatory Authority for Purposes of Authorizing Administrative Rules

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I hereby designate Dawn O'Toole, Chief Operating Officer, Agency of Human Services 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 Procedures Act, 3. V.S.A § 801 et seq.

CC: Dawn O'Toole via Dawn.OToole@vermont.gov

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: Sarah Copeland Hanzas, Secretary of State, Vermont Secretary of State Office
Rep. Trevor Squirrell, Chair, Legislative Committee on Administrative Rules (LCAR)

From: Leslie Wisdom, Deputy Commissioner, Department of Vermont Health Access

Cc: Dawn O'Toole, Chief Operating Officer, Agency of Human Services
Megan Cannella, Committee Assistant, Legislative Committee on Administrative Rules
Louise Corliss, APA Coordinator, Secretary of State's Office

Date: October 9, 2026

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:

- 26P020 HBEE Part One – General Provisions and Definitions
- 26P021 HBEE Part Two – Eligibility Standards
- 26P022 HBEE Part Three – Nonfinancial Eligibility Requirements
- 26P023 HBEE Part Five – Financial Methodologies
- 26P024 HBEE Part Seven – Eligibility and Enrollment Procedures

Public comments were received on HBEE Part Two and HBEE Part Seven during the public comment period. No comments were received for the other parts.

HBEE Part Seven was amended in response to comments from Vermont Legal Aid, Inc. (VLA). Please see the State's Responsiveness Summary and Summary of Changes at the end of each rule package for the list of changes from the proposed 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 Seven. No changes were made from the proposed rule in HBEE Part One, Part Three, and Part Five.

If you have any questions, please contact Emily Belanger, Policy Analyst, at 802-760-0118.

1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   26P020

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: Emily Belanger

   Agency: Agency of Human Services

   Mailing Address: 280 State Drive, NOB 1 South, Waterbury, Vermont 05671-1010

   Telephone: 802-760-0118 Fax: 802-241-0450

   E-Mail: emily.m.belanger@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: 5 Pilgrim Park, 1st Floor Suite 2, Waterbury VT 05671-1010

   Telephone: 802-241-0454 Fax: 802-241-0260

   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 and 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 rule amends part 1-3, 5 and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1,2,3,5 and 7 were last amended effective January 1, 2026. Substantive revisions include: newly requiring certain adult Medicaid applicants and enrollees demonstrate compliance with work and community engagement rules as a factor of eligibility; reducing the retroactive Medicaid coverage period from three months to one month for Adult coverage group enrollees and two months for all other enrollees; restricting non-citizen eligibility for both Medicaid and Qualified Health Plan premium tax credits and adding a new category of "eligible non-citizen" to clarify which individuals remain eligible; adjusting the renewal period from 12 to 6 months for Medicaid

enrollees in the Adult coverage group; shortening the annual open enrollment period from November 1st-January 15th to November 1st - December 28th. All of these substantive revisions are required by federal law.

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 federal and state 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:

Applicants and enrollees of Medicaid and Qualified Health Plans with financial assistance;

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

Health care providers;

Eligibility and enrollment assisters, including agents and brokers;

The Agency of Human Services including its departments;

The Vermont Department of Labor.

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

AHS anticipates that many of the proposed changes to HBEE carry an economic impact. Changes to eligibility criteria for certain non-citizens results in reduced enrollment in Medicaid and Qualified Health Plans. AHS anticipates that increased frequency of renewals for enrollees in the Medicaid Adult coverage group, as well as the introduction of new work and community engagement requirements, will reduce enrollment in Medicaid. The change to retroactive Medicaid periods represents a reduction in coverage for eligible

Medicaid enrollees. Overall, these changes may reduce total Medicaid enrollment, increase the number of uninsured people in Vermont, increase financial hardship on individuals and families impacted, and increase the burden of uncompensated care on healthcare providers and systems. The implementation and ongoing administration of these changes represent significant additional costs to the state. These costs have been quantified in a $5 million dollar project budget for implementation.

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: 8/14/2026

Time: 01:00 PM

Street Address: Agency of Human Services
Waterbury State Office Complex
Conference Room – Cherry A
280 State Drive
Waterbury, Vermont

Zip Code: 05671

URL for Virtual: Virtual Hearing-Phone or Microsoft Teams Call in (audio only) (802) 828-7667; Conference ID: 564 838 973#

https://teams.microsoft.com/meet/233297609116516?p=leCIIA3r4n2nvslTbO

Date:

Time: AM

Street Address:

Zip Code:

URL for Virtual:

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

Date:
Time: AM
Street Address:
Zip Code:
URL for Virtual:

21. DEADLINE FOR COMMENT (NO EARLIER THAN 7 DAYS FOLLOWING LAST HEARING):
8/21/2026

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

Health Benefits Eligibility and Enrollment
HBEE
Medicaid
Vermont Health Connect
QHP
Exchange
Qualified Health Plan
Health Benefit

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.

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1. TITLE OF RULE FILING:
   Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)
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 # 25P025, effective 1/1/2026; Part 2 - Eligibility Standards, SOS #25P026, effective 1/1/2026; Part 3 - Nonfinancial Eligibility Requirements, SOS # 25P027,

effective 1/1/2026; Part 5 - Financial Methodologies, SOS # 25P029, effective 1/1/2026; Part 7 - Eligibility and Enrollment Procedures, SOS # 25P030, effective 1/1/2026.

Interagency Committee on Administrative Rules (ICAR) Minutes

Date/Time: June 8, 2026, 2:00 PM

Location: Virtually via Microsoft Teams

Members Present: Chair Nick Kramer, Heidi Moreau, Patrick Murphy, Earl Fechter, John Kessler, Russ McCracken, Stephen Brown

Members Absent: Jennifer Mojo

Minutes By: Chrissy Gilhuly

- 2:00 p.m. meeting called to order.
- Review and approval of minutes from the May 11, 2026 meeting.
- No additions/deletions to agenda. Agenda approved as drafted.
- No public comments made.
- Presentation of Proposed Rules with recommended changes on pages to follow.

1. Vermont Department of Labor (VDOL) – Workers' Compensation Medical Fee Schedule Rule 40
    a. Medical providers who care for injured workers covered by a workers' compensation policy are required to bill for their services using the Workers' Compensation Medical Fee Schedule. It is vital to the health of the workers' compensation system that such fees be sufficient to ensure the provision of services, without being so generous as to increase the cost of insurance coverage. The rule generally modestly raises reimbursement amounts, adds a more robust table of Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes, and provides for annual indexing going forward using Centers for Medicare & Medicaid Services (CMS) "market basket" factors, capped at 3% annually.

2. Department of Fish and Wildlife (DFW) - 10 App. V.S.A. § 2, Report, Big Game (CVR 12-010-090)
    a. The proposed changes explicitly prohibit making false statements in the reporting of wild game taken, allow the Commissioner of Fish and Wildlife to pay a fee of at least one dollar per report to agents at authorized reporting stations, and make minor technical updates to the citations in the rule.

DRAFT

3. Department of Fish and Wildlife (DFW) - 10 App. V.S.A. § 2a. Big game; tagging (CVR 12-010-032)
    a. The proposed amendments are intended to clarify the big game tagging requirements regarding required tag information, requirements for individuals taking game on their own land, and tagging requirements for the transportation of animal parts. The proposed rule language requires that all big game carcasses are tagged with a tag that contains the name of the hunter and the applicable tag or permit number. This information is necessary for appropriate enforcement of license and permitting requirements.

4. Department of Fish and Wildlife (DFW) - 10 App. V.S.A. § 5. Bow and arrow and crossbow standards
    a. The proposed amendments continue to require the same arrowhead width and cutting edges but apply the standards to broadheads used with crossbows as well.

5. Department of Fish and Wildlife (DFW) - 10 App. V.S.A. § 12., Leashed tracking dogs (CVR 12-010-059)
    a. The proposed rule amendments make two changes to the existing leashed tracking dog rule. They amend the definition of "big game animal" to be consistent with the definition in 10 V.S.A. § 4001, to include all big game animals including moose. This will allow hunters to employ leashed tracking dogs to legally track dead or wounded moose. The proposed amendment also strikes language limiting tracking to big game seasons and the 24-hour period immediately following the season. This will allow for the use of tracking dogs to locate animals injured or killed outside the legal hunting seasons.

6. Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)
    a. This proposed rule amends part 1-3, 5 and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rule. Parts 1,2,3,5 and 7 were last amended effective January 1, 2026. Substantive revisions include: newly requiring certain adult Medicaid applicants and enrollees demonstrate compliance with work and community engagement rules as a factor of eligibility; reducing the retroactive Medicaid coverage period from three months to one month for Adult coverage group enrollees and two months for all other enrollees; restricting non-citizen eligibility for both Medicaid and Qualified Health Plan premium tax credits and adding a new category of "eligible non-citizen" to clarify which individuals remain eligible; adjusting the renewal period from 12 to 6 months for Medicaid enrollees in the Adult coverage group; shortening the annual open enrollment period from November 1st-January 15th to November 1st - December 15th. All of these substantive revisions are required by federal law.

7. Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2)

8. Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule,Nonfinancial Eligibility Requirements (Part 3)

9. Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5)

10. This proposed rule amends part 1-3, 5 and 7 of the 8- part Health Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7)

11. VOSHA Review Board - VOSHA Review Board Rules of Procedure
    a. These rules serve as a guide to the Review Board, its Clerk and Hearing Officers, and parties regarding the orderly transaction of its proceedings regarding contested VOSHA cases. There are two levels of review available to the parties through the Rules of Procedure. The first is through a hearing before a Hearing Officer. The second level is through a discretionary review by the Review Board, should a party (or the Review Board on its own motion) want to appeal the Hearing Officer's decision. There are two types of proceedings offered in the Rules: conventional and simplified. Simplified Proceedings offer employers (respondents) a less formal way to contest a citation (no answer needs to be filed and documents are exchanged freely without the use of discovery, generally). Rules regarding settlement and the parties' option of using Hearing Officers to mediate a settlement are covered in the Rules.

- Other business
  - Advice for completing APA forms – Approved forms for posting.
- Next scheduled meeting is July 13, 2026, at 2:00 p.m.
- 3:55 p.m. meeting adjourned.

To receive this information in an alternative format or for other accessibility requests, please contact:

Agency of Administration
ADM.Secretary@vermont.gov, 802-828-3322

DRAFT

Proposed Rule: Agency of Human Services (AHS) - Health Benefits Eligibility and Enrollment (HBEE) Rule, General Provisions and Definitions (Part 1-3, 5 and 7)

Presented By: Dani Fuoco

Motion made to accept ***all five parts*** of the HBEE rules by John Kessler, seconded by Stephen Brown, and passed unanimously, except for Heidi Moreau, who abstained, with the following recommendations:

1. **Economic Impact**
    a. #3: Typo in the word ineligible
    b. #8: Other – add positive impact if applicable
2. **Environmental Impact**
    a. #3: Repeat of answer to #2, adopting agency, instead of impact.

DRAFT

VERMONT LEGAL AID

The Office of the Health Care Advocate
264 North Winooski Avenue, Burlington, VT 05401
Helpline: 800-917-7787
www.vtlawhelp.org ▪ Fax: 802-863-7152

By email to: AHS.MedicaidPolicy@vermont.gov

August 20, 2026

Agency of Human Services
Medicaid Policy Unit
280 State Drive, Center Building
Waterbury, VT 05671-1000

Re: GCR 26-051 to 26-055 PROPOSED Health Benefits Eligibility and Enrollment (HBEE) Rules Update

Dear Medicaid Policy Unit,

Thank you for the opportunity to comment on the proposed changes in GCR 26-051 through 26-055. The Office of the Health Care Advocate (HCA) helps Vermonters navigate the complex healthcare landscape, which includes Vermont's Medicaid programs.

The HCA reviewed the Center for Medicare and Medicaid Services' Interim Final Rule on community engagement requirements against the Dept. of VT Health Access' proposed updates to the Health Benefits Eligibility & Enrollment (HBEE) rules. We submit the following for your consideration:

GCR 26-052: HBEE Part 2 – Eligibility Standards

Section 8.07 Medicare savings programs

> **Comment:** For housekeeping purposes, we suggest eliminating the now outdated references to past definitions of family size for the Medicare Savings Program. Specifically:

8.07(a)(4)(i) ~~Effective April 1, 2026, a~~An individual's family size includes the individual, their spouse who is living in the same household, if any, and anyone who is related to the individual by blood, adoption or marriage if they are living in the same household and are dependent on the individual or the individual's spouse for at least one-half of their financial support.43

~~(ii) Through March 31, 2026, an individual's family size is the same as the individual's Medicaid group (as defined in § 29.04) for purposes of MABD eligibility~~

GCR 26-055: HBEE Part 7 – Eligibility-and-Enrollment Procedures

Rule 70.01(b) Retroactive Eligibility

Comment: We suggest clarifying the proposed language to clearly indicate that enrollees are eligible for up to two months of retro coverage:

70.01(b)(1)(ii) For all other Medicaid eligible individuals, the retroactive period is ~~the second month~~ up to two months before the month the individual's application is received by AHS.

Section 71.02(e) AEOP & 71.02(f) Coverage effective dates during the AOEP

Comment: Currently, the annual Open Enrollment Period (AOEP) runs from November 1 to January 15. The draft language in HBEE 71.02(2) proposes shortening the period from November 1 to December 15 annually.

The HCA opposes shortening the AEOP. Vermont consumers face myriad complex choices as they consider what they can afford to pay for health care. Consumers need as much time as possible to weigh their decisions. When enhanced Advance Premium Tax Credits ended in 2026, many Vermont households left the marketplace or purchased a less expensive plan. Households need time to determine what makes sense for them. We hope that Vermonters will weigh their options carefully this OEP.

Data collected by the Department of VT Health Access (DVHA) in past years has shown that many consumers enroll or make plan changes between December 15 and January 15. We believe that a narrower open enrollment

period will lead to fewer Vermonters enrolling in health insurance. Many states have preserved their longer open enrollment period for 2027, and Vermont should do the same.

Thank you for your consideration of these comments. Please feel free to reach out to our office with any questions.

Sincerely,

/s/ Marjorie Stinchcombe
Helpline Director
Office of the Healthcare Advocate

/s/ Mike Fisher
Chief Health Care Advocate
Office of the Healthcare Advocate

/s/ Emma Zavez
Consumer Research & Health Policy Analyst
Office of the Healthcare Advocate

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

Date: October 19, 2026

Re: Response to comments received from the public for the Health Benefits Eligibility & Enrollment (HBEE) Rule Update (Proposed GCR 26-051 to 26-055)

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

Comments by Rule Sections

PART TWO

Section 8.07 Medicare savings programs

Comment from Vermont Legal Aid (VLA):

VLA states, "For housekeeping purposes, we suggest eliminating the now outdated references to past definitions of family size for the Medicare Savings Program. Specifically:

8.07(a)(4)(i) ~~Effective April 1, 2026, a~~An individual's family size includes the individual, their spouse who is living in the same household, if any, and anyone who is related to the individual by blood, adoption or marriage if they are living in the same household and are dependent on the individual or the individual's spouse for at least one-half of their financial support.43

(ii) Through March 31, 2026, an individual's family size is the same as the individual's Medicaid group (as defined in § 29.04) for purposes of MABD eligibility.

Response:

The agency appreciates the commenter's suggestion and thinks that it is an important obligation of the agency to eliminate outdated references as part of maintaining clear, accurate, and understandable rules. The agency does plan to revise this provision but will delay doing so until future rulemaking. The agency thinks it is helpful for now to maintain visibility in the rule of this recent transitional date. In addition to it serving as general awareness of the recent transition, maintaining the current text may also be beneficial for a while for appeal or audit purposes.

PART SEVEN

Section 70.01(b) Retroactive eligibility

Comment from VLA:

VLA states, "We suggest clarifying the proposed language to clearly indicate that enrollees are eligible for up to two months of retro coverage:

70.01(b)(1)(ii) For all other Medicaid eligible individuals, the retroactive period is ~~the second month~~ up to two months before the month the individual's application is received by AHS."

Response:

The agency appreciates the commenter's suggestion and thinks that its proposed language could also convey the intent of this rule provision. However, the current language more closely aligns with the language used by the Centers for Medicare & Medicaid Services (CMS) in its regulation on retroactive eligibility at 42 CFR 435.915. The agency thinks it is helpful to align the text in its rules with the text in federal regulations where it can and when appropriate. Accordingly, the agency will maintain its current text.

Section 71.02(e) AEOP

Section 71.02(f) Coverage effective dates during the AOEP

Comment from VLA:

VLA states, "Currently, the annual Open Enrollment Period (AOEP) runs from November 1 to January 15. The draft language in HBEE 71.02(2) proposes shortening the period from November 1 to December 15 annually.

The HCA opposes shortening the AEOP. Vermont consumers face myriad complex choices as they consider what they can afford to pay for health care. Consumers need as much time as possible to weigh their decisions. When enhanced Advance Premium Tax Credits ended in 2026, many Vermont households left the marketplace or purchased a less expensive plan. Households need time to determine what makes sense for them. We hope that Vermonters will weigh their options carefully this OEP.

Data collected by the Department of VT Health Access (DVHA) in past years has shown that many consumers enroll or make plan changes between December 15 and January 15. We believe that a narrower open enrollment period will lead to fewer Vermonters enrolling in health insurance. Many states have preserved their longer open enrollment period for 2027, and Vermont should do the same."

Response:

Thank you for this comment. The agency has extended the annual Open Enrollment Period (AOEP) so that open enrollment runs November 1 through December 28. While the agency now has flexibility from the federal government to extend past the original planned December 15 end of AOEP, the agency is not able this year to extend the AOEP beyond January 1, 2027. Vermont has HR1 systems considerations at play this year that impact its decision to close AOEP on 12/28: a late December systems deployment of HR1 Medicaid changes (Medicaid work requirements and 6-month renewals for the new adult group) and required HR1 qualified health plan immigration eligibility rules changes. Extending AOEP into calendar year 2027 for the 2027 plan year is not possible operationally due to the systems changes that are being implemented at the end of December 2026 for the required HR1 Medicaid and qualified health plan changes.

The agency is amending section 71.02(e) to reflect that the AOEP runs from November 1 through December 28th. The agency is making conforming amendments in 71.02(f), which describes the effective dates of enrollment following plan selection during the AOEP.

State of Vermont
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 19, 2026

Re: Summary of Changes from proposed to final proposed rule filing for Health Benefits Eligibility and Enrollment (HBEE) rules (GCR 26-051 through GCR 26-055)

In addition to the change being made in response to public comments (see responsiveness summary), additional changes are being made to align the rule with changes made in federal law since the filing of the proposed rule.

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 12.05 – To align more closely with federal law at 45 CFR 155.305(f)(4), replace "two consecutive years" with "a year" on the third line of text; delete "and for the previous year" on the fifth line of text.

PART SEVEN

Section 55.02 – To align more closely with federal law at 45 CFR 155.320(c)(3)(ix), add a new subsection (f).

Section 61.00(d) – To align more closely with federal law at 42 CFR 435.912(e), add "than the standards in paragraph (c) above" on the first line of text; add a new subparagraph (4).

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.

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1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)

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:

   Parties impacted:

   Applicants and enrollees of Medicaid and Qualified Health Plans with financial assistance;

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

Health care providers;

Eligibility and enrollment assisters, including agents and brokers;

The Agency of Human Services including its departments;

The Vermont Department of Labor.

Anticipated costs and benefits of this rule:

AHS anticipates that many of the proposed changes to HBEE carry an economic impact. As a result of restrictions to non-citizen Medicaid eligibility, less than 300 non-citizen enrollees, including certain asylees and refugees, will be disenrolled from Medicaid.

Changes to non-citizen eligibility for Advance Premium Tax Credits and Cost-Sharing Reductions will reduce the number of Qualified Health Plan (QHP) enrollees able to purchase a QHP with financial assistance. AHS anticipates that individuals who become ineligible for financial assistance will disenroll from Marketplace coverage. AHS expects less than 100 QHP enrollees to be impacted by these changes.

The introduction of new work and community engagement rules for the Medicaid Adult coverage group will impact a potential total of 49,000 adults- although AHS estimates that many of these adults are likely either already meeting this new requirement or will have an exemption from the work rules. These new rules will likely reduce the number of applicants who are found eligible for or who remain enrolled in Medicaid. Individuals who are found ineligble for Medicaid due to failure to meet work or community engagement rules are considered ineligible to enroll in QHPS with financial assistance. These changes are expected to increase the percentage of adults in Vermont without healthcare coverage.

The new work and community engagement rules necessitate new verification processes, associated with significant increases in administrative costs. Additional administrative costs are also associated with the introduction of more frequent eligibility renewal cycles for Adult coverage group enrollees. Both of these changes will decrease the percentage of Medicaid enrollees who are successfully renewed automatically, without requiring the enrollee to complete paperwork. AHS estimates that these changes will place many Adult coverage group enrollees at risk of disenrollment from Medicaid.

The reduced availability of retroactive Medicaid coverage, from 3 months to 2 months for most enrollees, and 1 month for Adult coverage group enrollees, reduces Medicaid coverage and shifts healthcare costs onto individuals and providers.

The cumulative anticipated impact of these changes is an overall reduced enrollment in Medicaid. This will result in reduced Medicaid spending. This will also likely increase the number of uninsured individuals in Vermont, creating financial hardship for those impacted and their families, and adding to the burden of uncompensated care throughout Vermont's healthcare systems.

AHS intends to implement these changes in a way that minimizes enrollment loss, but the implementation and ongoing administration of these changes represent significant costs to the state, including expenses related to staffing, contracts, and information technology (IT) updates necessary to comply with these new federal requirements. These costs have been quantified in a $5 million dollar project budget for implementation. AHS has received one-time Federal grants in the amounts of ~$2 million and ~$200,000. These funds are available for certain updates necessary to implement these changes.

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 benenfits 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

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1. TITLE OF RULE FILING:

   Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1)

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 anticipated.

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 anticipated.

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

6. RECREATION: *EXPLAIN HOW THE RULE IMPACTS RECREATION IN THE STATE:*
   No impact anticipated.
7. CLIMATE: *EXPLAIN HOW THE RULE IMPACTS THE CLIMATE IN THE STATE:*
   No impact anticipated.
8. OTHER: *EXPLAIN HOW THE RULE IMPACT OTHER ASPECTS OF VERMONT'S ENVIRONMENT:*
   No impact anticipated.
9. SUFFICIENCY: *DESCRIBE HOW THE ANALYSIS WAS CONDUCTED, IDENTIFYING RELEVANT INTERNAL AND/OR EXTERNAL SOURCES OF INFORMATION USED.*
   Not applicable.

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, General Provisions and Definitions (Part 1)

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. AHS took input from the Office of the Health Care Advocate/Vermont Legal Aid, Qualified Health Plan issuers, assisters, providers, and members through the Medicaid & Exchange Advisory Committee.

   The proposed rule was posted on the AHS website for public comment, and a public hearing was held on August 14, 2026. No one attended the hearing. When the rule is filed with the Office of the Secretary of State, AHS provides notice and access to the rule, through the Global Commitment Register, to all persons who subscribe to the Global Commitment Register.

   The public comment period ended August 21, 2026. Comments were received from Vermont Legal Aid on Part 2 and Part 7 of the HBEE rule. Part 7 has been amended in response to comments since the proposed filing. The

comments received and responsiveness summary are included with this filing.

Part 2 and Part 7 have also been amended since the proposed filing to bring the rule into alignment with recently issued federal regulations. These changes are included in the Global Commitment Register Notice as well as the Summary of Changes memo attached to this filing. There are no changes to Parts 1, 3, and 5 since the proposed filing.

The Global Commitment Register is a database that provides notification of policy changes and clarification 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 provide comment and be 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;

Exchange Advisory Committee;

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

Eligibility and enrollment assisters, including agents and brokers;

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

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Part One
General Provisions and Definitions

1.00 Administration of health benefits (01/15/2017, GCR 16-094)

The Agency of Human Services (AHS) was created in 1969 to serve as the umbrella organization for all human-service activities within state government. It is the Single State Agency for Medicaid purposes and the adopting authority for this rule.

2.00 General description of health benefits in Vermont (subject to specific criteria in subsequent sections) (01/01/2024, GCR 23-082)

2.01 Types of health benefits (01/15/2017, GCR 16-094)

(a) In general. The state offers several types of health benefits, including:

- Medicaid;
- Children's Health Insurance Program (CHIP);
- Enrollment in a Qualified Health Plan (QHP) with financial assistance.

The benefits for which a person is eligible is determined based on the individual's income, resources (in specified cases), and circumstances as covered in succeeding sections.

(b) Benefit choice. Except as may be otherwise restricted, an individual may select the particular health benefit or benefits that they wish to be considered for. In the absence of such a selection, AHS will determine an individual's eligibility for the most advantageous benefit that they qualify for.

(c) Redetermination of eligibility. If an individual becomes ineligible for one benefit, AHS will determine eligibility for the next most advantageous benefit that they then qualify for.

2.02 Medicaid (01/01/2024, GCR 23-082)

(a) Overview of the Medicaid Program. The Medicaid program is authorized in Title XIX of the Social Security Act (the Act).

(b) Medicaid eligibility. Vermont provides Medicaid to those who meet the requirements of one of three eligibility groups:

- Mandatory categorically needy;
- Optional categorically needy; and
- Medically needy.

To be eligible for federal funds, states are required to provide Medicaid coverage for certain groups of individuals. These groups–the mandatory categorically needy–derive from the historic ties to programs that provided federally-assisted income-maintenance payments (*e.g.*, SSI and Aid to Families with Dependent Children). States are also required to provide Medicaid to related groups not receiving cash payments.

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined.

The medically-needy option allows states to extend Medicaid eligibility to additional groups of people. These individuals would be eligible for Medicaid under one of the mandatory or optional groups, except that they do not meet the income or resource standards for those groups. Individuals may qualify immediately or may "spend down" by incurring medical expenses greater than the amount by which their income or resources exceed their state's medically-needy standards.[1]

(c) Vermont's Medicaid Program. The Vermont Medicaid program covers all mandatory categories of enrollees. It also offers all mandatory services—general hospital inpatient; outpatient hospital and rural health clinics; other laboratory and x-ray; nursing facility, Early Periodic Screening, Diagnosis and Treatment (EPSDT), and family planning services and supplies; physician's services and medical and surgical services of a dentist; home health services; and nurse-midwife and nurse practitioner services.[2] Vermont includes certain, but not all, optional categories of enrollees. Vermont has also elected to cover certain, but not all, optional services for which federal financial participation is available. It also operates health care programs permitted by research demonstration waiver authority under § 1115 of the Social Security Act.

Vermont is authorized to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of coverage in the optional categories[3] based on such criteria as medical necessity or utilization control.[4] In establishing such standards for coverage, Vermont ensures that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service.[5] Vermont may not limit services based upon diagnosis, type of illness, or condition.[6]

2.03 Children's Health Insurance Program (CHIP) (01/01/2018, GCR 17-043)

(a) In general. CHIP (known from its inception until March 2009 as the State Children's Health Insurance Program, or SCHIP) is authorized by Title XXI of the Social Security Act.

(b) Vermont CHIP. Vermont utilizes CHIP to provide health coverage to uninsured children with household incomes above 237% and at or below 312% of the federal poverty level (FPL). CHIP is part of the coverage array known as "Dr. Dynasaur." All of the provisions in this rule that apply to the "child" Medicaid coverage

[1] In Vermont, the Medically Needy Income Level is known as the "Protected Income Level," or "PIL."

[2] For rules that govern Medicaid covered services, refer to Health Care Administrative Rules (HCAR).

[3] 42 USC § 1396a(a)(17).

[4] 42 CFR § 440.230(d).

[5] 42 CFR § 440.230(b).

[6] 42 CFR § 440.230(c).

group (§ 7.03(a)(3)) apply with equal effect to an individual who is enrolled in CHIP.

2.04 The Health Benefits Exchange (01/15/2019, GCR 18-060)

(a) In general. Vermont has elected to establish and operate its own Exchange. Vermont Act No. 48 of 2011, "An act relating to a universal and unified health system," established the Vermont health benefit exchange (Vermont Health Connect, VHC). The purpose of VHC is to facilitate the purchase of affordable, qualified health benefit plans by individuals, and small employers in the merged individual and small group markets; and later in the large group market in Vermont in order to reduce the number of uninsured and underinsured; to reduce disruption when individuals lose employer-based insurance; to reduce administrative costs in the insurance market; to contain costs; to promote health, prevention, and healthy lifestyles by individuals; and to improve quality of health care.

Qualified health plans (QHPs) must provide a comprehensive set of services (essential health benefits), meet specific standards for actuarial value and the limitation of cost-sharing.

Additionally, catastrophic plans are available to certain individuals.

The state will certify health plans offered through VHC on an annual basis.

(b) Financial assistance through VHC. Eligible individuals who purchase insurance through VHC may receive federal premium tax credits and Vermont premium reductions. Some also qualify for federal and Vermont cost-sharing reductions (CSR).

Federal premium tax credits are available to eligible individuals and families with incomes up to 400 percent of the FPL to purchase insurance through VHC.[7]

The state will supplement the federal premium tax credits with premium reductions for individuals and families with income at or below 300% of the federal poverty level.

In addition to premium subsidies, eligible individuals receive federal and state CSRs for silver level plans (see level of coverage in § 3.00) and in other limited circumstances. These subsidies reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the plan.

Modified adjusted gross income (MAGI) is used to determine eligibility for federal and state premium subsidies and CSRs. In order to be eligible for federal CSR, state premium reductions and state CSR, the individual must be eligible for federal premium tax credits.[8]

(c) Administrative Requirements. Federal health-care regulations contain a number of provisions aimed at the administration of the health-benefits eligibility-determination process. These provisions are intended to promote administratively-efficient, streamlined, and coordinated eligibility business processes.

[7] 26 CFR § 1.36B-2.

[8] See, 26 CFR § 1.36B-2.

2.05 Administration of eligibility for health benefits (01-01-2024, GCR 23-082)

(a) AHS administers eligibility for the state's health-benefits programs and for enrollment in a QHP in accordance with applicable provisions of federal and state law and regulations.

(b) The eligibility determination process is administered such that:

(1) Individual dignity and self-respect are maintained;

(2) The constitutional and other legal rights of individuals are respected;

(3) Practices do not violate the individual's privacy or dignity or harass the individual in any way;

(4) Disclosure of information concerning applicants or enrollees is limited to purposes directly connected with the administration of the applicable health-benefits program or with enrollment in a QHP or as otherwise required by law;

(5) Each individual who wishes to do so is given an opportunity to apply or reapply for benefits without delay;

(6) Prompt action is taken on each application and reapplication and individuals are notified in writing of the decision on the application;

(7) Decisions are based on recorded information showing either that all pertinent eligibility requirements are met or that one or more requirements are not met;

(8) Benefits are given promptly and continue regularly to all eligible individuals until they are found to be ineligible;

(9) Eligibility is redetermined when circumstances change or at the time of renewal, in accordance with the same principles as initial application;

(10) Individuals are the primary sources of information about their eligibility;

(11) Individuals are informed of their responsibility to furnish complete and accurate information, including prompt notification of changes affecting their eligibility or amount of aid or benefits, and of the penalties for willful misrepresentation to obtain benefits to which they are not entitled;

(12) Individuals are helped to obtain needed information; and

(13) Verification of conditions of eligibility are limited to what is reasonably necessary to assure that expenditures under a health-benefits program are legal, in accordance with federal and state law and regulations.

(c) Application of these principles in specific areas is covered in succeeding sections.

3.00 Definitions and use of terms (01/01/2027~~01/01/2026~~, GCR 26-0512~~25-050~~)

As used in this rule:

Adjusted monthly premium.[9] The premium an insurer charges for the applicable benchmark plan (ABP) to cover all members of the tax filer's coverage family.

Advance payment of the premium tax credit (APTC).[10] The payment of premium tax credits specified in section 36B of the Internal Revenue Code that are provided on an advance basis on behalf of an eligible individual enrolled in a QHP through VHC and paid directly to the QHP issuer.

Affordable Care Act (ACA).[11] The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

Aid to the Aged, Blind, or Disabled (AABD).[12] Vermont's supplemental security income (SSI) state supplement program.

Alternate reporter. A person who is authorized to receive either original notifications or copies of such notifications on behalf of an individual. See, § 5.02(b)(1)(iv).

Annual open enrollment period (AOEP).[13] The period each year during which a qualified individual may enroll or change coverage in a QHP. See, § 71.02.

Applicable benchmark plan (ABP).[14] See, § 60.06.

Applicant[15]

(a) An individual seeking eligibility for health benefits for themselves through an application submission.

(b) An employer or employee seeking eligibility for enrollment in a QHP, where applicable.

Application.[16] A single, streamlined application for health benefits, submitted by or on behalf of an applicant. For determining eligibility on a basis other than the applicable MAGI standard, the single, streamlined application may be

[9] 26 CFR § 1.36B-3(e).

[10] 42 CFR § 435.4; 45 CFR § 155.20; § 36B of the Code (as added by § 1401 of the ACA); 33 VSA § 1812.

[11] 26 CFR § 1.36B-1(j); 42 CFR § 435.4; 45 CFR § 155.20.

[12] 33 VSA § 1301 et seq.; AABD Rule 2700 et seq.

[13] 45 CFR § 155.20.

[14] 26 CFR § 1.36B-3(f).

[15] 42 CFR § 435.4; 45 CFR §§ 155.20 and 156.20.

[16] 42 CFR § 435.4; 45 CFR § 155.410(a).

supplemented with form(s) to collect additional information needed, or an appropriate alternative application may be used.

Application date

(a) The day the application is received by AHS, if it is received on a business day; or

(b) The first business day after the application is received, if it is received on a day other than a business day.

If an application is supplemented with form(s) to collect additional information, including the use of an alternative application, the application date is the date the initial application is received by AHS.

Application filer[17]

(a) An applicant;

(b) An adult who is in the applicant's household;

(c) An authorized representative of the applicant; or

(d) If the applicant is a minor or incapacitated, someone acting responsibly for the applicant.

Approve. For purposes of eligibility for health benefits, to determine that an individual is eligible.

Authorized representative. A person or entity designated by an individual to act responsibly in assisting the individual with their application, renewal of eligibility and other ongoing communications. See, § 5.02.

Benefit year (or taxable year).[18] A calendar year for which a health plan provides coverage for health benefits.

Broker.[19] A person or entity licensed by the state as a broker or insurance producer.

Business day. Any day during which state offices are open to serve the public.

Caretaker relative[20]

(a) A relative of a dependent child (as defined in this § 3.00) by blood, adoption, or marriage, with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by

[17] 42 CFR § 435.907; 45 CFR § 155.20.

[18] 45 CFR §§ 155.20 and 156.20. The Treasury regulations employ the term "taxable year." The Internal Revenue Code defines the "benefit year" as "the calendar year, or the fiscal year ending during such calendar year, upon the basis of which the taxable income is computed under subtitle A. . . ." 26 USC § 7701(a)(23). For most individuals, the benefit year is the calendar year, and thus, synonymous with the Exchange regulation's definition of "benefit year."

[19] 45 CFR § 155.20.

[20] 42 CFR § 435.4.

claiming the child as a tax dependent for Federal income tax purposes).

(b) As used in this definition, a "relative" is the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece. The term relative includes:

(1) An individual connected to the child by blood, including half-blood;

(2) An individual of preceding generations denoted by grand, great, or great-great;

(3) The spouse or civil-union partner of such relative, even after the marriage or union is terminated by death or dissolution; and

(4) An adult not related to the child by blood, adoption, or marriage, but who lives with the child and has primary responsibility for the child's care.

Case file. The permanent collection of documents and information required to determine eligibility and to provide benefits to individuals.

Categorically needy.[21] Families and children; aged, blind, or disabled individuals; and pregnant women, described under subparts B and C of 42 CFR part 435 who are eligible for Medicaid. Subpart B describes the mandatory eligibility groups who, generally, are receiving or are deemed to be receiving cash assistance under the Act. These mandatory groups are specified in §§ 1902(a)(10)(A)(i),1902(e),1902(f), and 1928 of the Act. Subpart C describes the optional eligibility groups of individuals who, generally, meet the categorical requirements or income or resource requirements that are the same as or less restrictive than those of the cash assistance programs and who are not receiving cash payments. These optional groups are specified in §§ 1902(a)(10)(A)(ii),1902(e), and 1902(f) of the Act.

Catastrophic plan.[22] A health plan available to an individual up to age 30 or to an individual who is exempt from the mandate to purchase coverage that:

(a) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market;

(b) Does not provide a bronze, silver, gold, or platinum level of coverage; and

(c) Provides coverage of essential health benefits once the annual limitation on cost sharing is reached, with the following exceptions:

(1) A catastrophic plan must provide coverage for at least three primary-care visits per year before reaching the deductible.

(2) A catastrophic plan may not impose any cost-sharing requirements for preventive services, in accordance

[21] 42 CFR § 435.4.

[22] 45 CFR § 156.155.

with § 2713 of the Public Health Service Act.

Certified application counselors. Staff and volunteers of organizations who are authorized and registered by AHS to provide assistance to individuals with the application process and during renewal of eligibility. See, § 5.05

Close. For purposes of eligibility for health benefits, to determine that an enrollee is no longer eligible to receive health benefits.

Code. Internal Revenue Code.

Community maintenance allowance. See, § 24.04(c).

Community spouse (CS). For purposes of Medicaid, the spouse of an institutionalized individual who is not living in a medical institution or a nursing facility. An individual is considered a community spouse even when receiving Medicaid coverage of long-term care services and supports in a home and community-based setting if they are the spouse of an individual who is also receiving Medicaid coverage of long-term care services and supports.

Cost sharing.[23] For purposes of QHP, any expenditure required by or on behalf of an individual with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance-billing amounts for non-network providers, and spending for non-covered services.

Cost-sharing reductions (CSR).[24] Reductions in cost sharing (as defined in this § 3.00) for an individual who is enrolled in a silver-level QHP or for an individual who is an Indian enrolled in a QHP.

Couple. Two individuals who are married to each other or are parties to a civil union, according to the laws of the State of Vermont, except, for purposes of APTC/CSR, two individuals who are married to each other within the meaning of 26 CFR § 1.7703-1. IRS's regulations do not recognize parties to civil unions as married couples. Couples in civil unions are not permitted to file joint federal tax returns, but may qualify for APTC/CSR by filing separate tax returns.

Coverage family.[25] See, § 60.02(b).

Coverage group.[26] Category of Medicaid eligibility, defined by particular categorical, financial, and nonfinancial criteria.

Coverage island. A discrete period of Medicaid coverage that is available in certain defined circumstances. See, § 70.02(d).

Date of application. See definition of "application date" in this § 3.00.

[23] 45 CFR §§ 155.20 and 156.20.

[24] 45 CFR §§ 155.20 and 156.20; 33 VSA § 1812.

[25] 26 CFR § 1.36B-3(b)(1).

[26] 42 CFR § 435.10(b).

Day. A calendar day unless a business day is specified.

Deny. For purposes of eligibility for health benefits, to determine that an applicant is ineligible.

Dependent child.[27] For purposes of Medicaid eligibility, an individual who is:

(a) Under the age of 18; or

(b) Age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

Disability

(a) Individual age 18 and older. An individual age 18 and older is considered disabled if they are unable to engage in any substantial gainful activity because of any medically-determinable physical or mental impairment, or combination of impairments, that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not fewer than 12 months. To meet this definition, an individual must have a severe impairment, which makes them unable to do their previous work or any other substantial gainful activity that exists in the national economy. To determine whether an individual is able to do any other work, AHS considers their residual functional capacity, age, education, and work experience.

(b) Individual under age 18. An individual under age 18 is considered disabled if they have a medically-determinable physical or mental impairment, or combination of impairments, resulting in marked and severe functional limitations, that can be expected to result in death or that have lasted or can be expected to last for at least 12 consecutive months. An individual under age 18 who engages in substantial gainful activity may not be considered disabled.

Disenroll. To end coverage.

Dr. Dynasaur. The collection of programs that provide health benefits to children under age 19 in the group defined in § 7.03(a)(3) and pregnant women in the group defined in § 7.03(a)(2).

Electronic account.[28] An electronic file that includes all information collected and generated by the state regarding each individual's health-benefits eligibility and enrollment, including all documentation required under § 4.04 and including information collected or generated as part of a fair hearing process conducted with regard to health-benefits eligibility and enrollment.

Eligible. The status of an individual determined to meet all financial and nonfinancial qualifications for health benefits.

Eligible employer-sponsored plan[29]

(a) With respect to an employee, a group health plan or group health insurance coverage offered by an employer

[27] 42 CFR § 435.4.

[28] 42 CFR §§ 435.4 and 435.914.

[29] 26 CFR § 1.36-2(c)(3)(i); 26 USC § 5000A(f)(2).

to the employee which is:

(1) A governmental plan (within the meaning of § 2791(d)(8) of the Public Health Service (PHS) Act); or

(2) Any other plan or coverage offered in the small or large group market within a state.

(b) This term also includes a grandfathered health plan[30] offered in a group market.

Eligibility determination.[31] An approval or denial of eligibility as well as a renewal or termination of eligibility.

Eligibility process. Activities conducted for the purposes of determining, redetermining, and maintaining the eligibility of an individual.

Employer contributions.[32] Any financial contributions toward an employer-sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enroll. For purposes of eligibility for health benefits, to initiate coverage for an approved individual.

Enrollee.[33] An individual who has been approved and is currently receiving health benefits. The term “enrollee” includes the term “beneficiary,’ which is an individual who has been determined eligible for, and is currently receiving, Medicaid.

Exchange (Vermont Health Connect (VHC)).[34] A state-managed entity through which individuals, qualified employees, and small businesses can compare, shop for, purchase, and enroll in QHPs; and individuals can apply for and enroll in health-benefits programs. In Vermont, the Exchange is known as Vermont Health Connect (VHC).

Exchange service area.[35] The area in which the Exchange (in Vermont, VHC) is certified to operate.

Family coverage.[36] Health insurance that covers more than one individual and provides coverage for essential health benefits.

[30] 26 USC § 5000A(f)(1)(D).

[31] 42 CFR § 435.4. See, also, 42 CFR §§ 435.911 and 435.916; 45 CFR § 155.302.

[32] 45 CFR § 155.20.

[33] 42 CFR § 435.4.

[34] 26 CFR § 1.36B-1(k); 45 CFR § 155.20. There will be a single “service area” in Vermont, for both Medicaid and QHP enrollment.

[35] 45 CFR § 155.20.

[36] 26 CFR § 1.36B-1(m).

Family size. See, § 28.02(a).

Federal poverty level (FPL).[37] The poverty guidelines most recently published in the Federal Register by the Secretary of HHS under the authority of 42 USC § 9902(2), as in effect for the applicable budget period used to determine an individual's income eligibility for means-tested health benefits.

Financial responsibility group. For purposes of MABD, the individuals whose income or resources are considered when determining eligibility for a Medicaid group (defined below). See § 29.03 for rules on the formation of the financial responsibility group for MABD eligibility purposes.

Grace period. The period of time during which an enrollee who has failed to pay all outstanding premiums remains enrolled in coverage, with or without pended claims.

Grandfathered health plan coverage.[38] Coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under federal criteria).

Group health plan.[39] An employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Health-benefits program.[40] A program that is one of the following:

(a) A state Medicaid program under Title XIX of the Act.

(b) A state children's health insurance program (CHIP) under Title XXI of the Act.

(c) A program that makes available coverage in QHPs with financial assistance.

Health benefits. Any health-related program or benefit, administered or regulated by the state, including, but not limited to, QHPs, APTC, premium reductions, federal or state CSR, and Medicaid.

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[37] 26 CFR § 1.36B-1(h); 42 CFR § 435.4; 45 CFR § 155.410. The Treasury regulations uses the term “FPL” to describe this indicator: “FPL. The FPL means the most recently published poverty guidelines (updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 USC § 9902(2)) as of the first day of the regular enrollment period for coverage by a QHP offered through an Exchange for a calendar year. Thus, the FPL for computing the premium tax credit for a benefit year is the FPL in effect on the first day of the initial or annual open enrollment period preceding that benefit year. See 45 CFR 155.410.” 26 CFR § 1.36B-1(h). For the sake of consistency, AHS has adopted HHS’s term for this concept, and uses it throughout this rule.

[38] 45 CFR § 155.20; 45 CFR § 147.140.

[39] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 45 CFR § 146.145(a).

[40] This term includes the programs referred to as “insurance affordability programs” in federal regulations. See, 42 CFR § 435.4; 45 CFR § 155.300.

Health insurance coverage.[41] Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

Health insurance issuer or issuer.[42] An insurance company, nonprofit hospital and medical service corporation, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance (within the meaning of section 514(b)(2) of ERISA).

Health plan.[43] This term has the meaning given in § 1301(b)(1) of the ACA. That section incorporates the definition found in § 2791(a) of the Public Health Service Act.

Human Services Board. AHS's fair hearings entity for eligibility issues. See, § 80.01.

Indian.[44] A person who is a member of an Indian tribe.

Indian tribe.[45] Any Indian tribe, band, nation or other organized group, or community, including pueblos, rancherias, colonies and any Alaska Native Village, or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual. An applicant or enrollee for health benefits.

Institution.[46] An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

Institutionalized individual. A person requesting Medicaid coverage of long-term care services and supports, whether the care is received in a home and community-based setting or in an institution licensed by AHS.

Institutionalized spouse (IS). For purposes of Medicaid, an institutionalized individual whose spouse qualifies as a community spouse.

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[41] 45 CFR § 155.20; 45 CFR § 144.103.

[42] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 18 VSA § 9402(8).

[43] 45 CFR § 155.20.

[44] 25 CFR § 900.6.

[45] 25 CFR § 900.6.

[46] 42 CFR § 435.1010. This is the definition referred to in 42 CFR § 435.403(b) and 45 CFR § 155.305(a)(3). "Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. Former PP&D to Former Medicaid Rule 4201.

Interpreter. A person who orally translates for an individual who has limited English proficiency or an impairment. See, § 4.02(j).

Lawfully present. See, § 17.01(g).

Level of coverage.[47] One of four standardized actuarial values for plan coverage as defined by § 1302(d)(1) of the ACA: bronze, silver, gold or platinum.

Limited English proficiency. An ineffective ability to communicate in the English language for individuals who do not speak English as their primary language and may be entitled to language assistance with respect to a particular type of service, benefit or encounter.

Long-term care. Highest-need and high-need care, as determined by AHS, received by an individual living in a nursing facility, rehabilitation center, intermediate-care facility for the developmentally disabled (ICF-DD), and other medical facility for at least 30 consecutive days. It also includes care received by an individual in a home and community-based setting as specified in relevant waiver authorizations and any related program regulations.

For more information on Vermont's waiver governing terms and conditions, see: http://dvha.vermont.gov/administration.

Long-term care services and supports.[48] A range of medical, personal, and social services that can help an individual with functional limitations live their life more independently. Supports range from daily living (e.g. grocery shopping and food preparation) to 24-hour medical care provided in nursing facilities. Examples of long-term care services and supports include nursing facility services; a level of care in any institution equivalent to nursing facility services; home and community-based services to qualifying individuals as specified in relevant waiver authorizations or in any related program regulations, to include:

(a) Home-based and enhanced residential care services for the aged and disabled (known as "Choices for Care");

(b) Brain injury services;

(c) Home and community-based waiver services for the developmentally disabled (DS); and

(d) Children's mental health services.

For more information on Vermont's waiver governing terms and conditions, see: http://dvha.vermont.gov/administration. See, also, DVHA's Medicaid Covered Services Rule 7601.

Low-income Subsidy application data (LIS leads data). See, § 58.01(g).

MAGI-based income.[49] See, § 28.03.

[47] 45 CFR § 156.20; § 1302(d)(2) of the ACA.

[48] 42 CFR § 435.603(j)(4).

[49] 42 CFR §§ 435.4 and 435.603(e).

Medicaid for Children and Adults (MCA). The health-benefits program available to a member of a Medicaid coverage group for parents and other caretaker relatives, children, pregnant women, or adults under 65 years of age.

Medicaid for the Aged, Blind, and Disabled (MABD). The health-benefits program available to a member of a Medicaid coverage group for people who are aged, blind, or disabled. MABD is based on the requirements for two financial assistance programs federally administered by the Social Security Administration (SSA): the supplemental security income program (SSI) and aid to the aged, blind, and disabled program (AABD).

Medicaid group. Individuals who are considered in the financial-eligibility determination for MABD. The countable income and resources of the financial responsibility group are compared against the income and resource standards applicable to the Medicaid group's size. See § 29.04 for rules on the formation of the Medicaid group.

Medicaid services.[50] Medical benefits funded through Medicaid as specified in related program rules and waiver authorizations.

Medical incapacity. See, § 64.09.

Medical institution.[51] An institution that:

(a) Is organized to provide medical care, including nursing and convalescent care;

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients on a continuing basis and in accordance with accepted standards;

(c) Is authorized under state law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

Medically needy.[52] Families; children; individuals who are aged, blind, or disabled; and pregnant women who are not categorically needy but who may be eligible for Medicaid because their income and, for individuals who are aged, blind or disabled, their resources are within limits set by the state under its Medicaid plan (including persons whose income and, if applicable, resources fall within these limits after their incurred expenses for medical or remedial care are deducted).

Medicare savings programs. See, § 8.07.

[50] *See,* Health Care Administrative Rules (HCAR) and Global Commitment to Health Section 1115 Waiver.

[51] 42 CFR § 435.1010.

[52] 42 CFR § 435.4.

Minimum essential coverage (MEC).[53] Health coverage under government-sponsored programs, employer-sponsored plans that meet specific criteria, grandfathered health plans, individual health plans, and certain other health-benefits coverage. See, § 23.00.

Minimum value.[54] When used to describe coverage in an eligible employer-sponsored plan, minimum value means that 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.

Modified adjusted gross income (MAGI). See, § 28.00.

Navigator.[55] An entity or individual selected by AHS and awarded a grant to provide assistance to individuals and employers with enrollment in Medicaid programs and qualified health plans, and to engage in the activities and meet the standards described in § 5.03.

Non-applicant.[56] A person who is not seeking an eligibility determination for himself or herself and is included in an applicant's or enrollee's household to determine eligibility for such applicant or enrollee.

Nonpayment. Failure to pay any or all of a premium due.

OASDI.[57] Old age, survivors, and disability insurance under Title II of the Act.

Optional state supplement.[58] A cash payment made by a state, under § 1616 of the Act, to an aged, blind, or disabled individual. *See*, AABD.

Patient share. See, § 24.00.

Personal needs allowance. See, § 24.04(c).

Physician's certificate. See, § 64.09.

Plan year.[59] A consecutive 12-month period during which a health plan provides coverage. For plan years beginning on January 1, 2015, a plan year must be a calendar year.

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[53] 42 CFR § 435.4; 45 CFR § 155.20.

[54] 45 CFR § 155.300; 45 CFR § 156.145; 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

[55] 45 CFR § 155.20; 33 VSA § 1807.

[56] 42 CFR § 435.4.

[57] 42 CFR § 435.4.

[58] 42 CFR § 435.4.

[59] 45 CFR §§ 155.20 and 156.20.

Plain language.[60] Language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.

Pregnant woman.[61] A woman during pregnancy and the post partum period, which begins on the date the pregnancy ends and extends 12 months, and then ends on the last day of the month in which the 12-month period ends. ~~The 12-month post partum period is extended to a woman who was still enrolled in Medicaid on April 1, 2023 and was pregnant or within 12 months of the end of a pregnancy on that date.~~

Premium

(a) In general. A monthly charge that must be paid by an individual in order to receive health benefits.

(b) Initial premium. The premium for the first month of coverage.

(c) Ongoing premium. The premium for successive months of coverage, which are billed and due on a monthly basis.

Premium due date. The day on which a health-benefits premium is due.

Premium Reduction. State subsidy paid directly to the QHP issuer to reduce monthly premiums for an eligible individual enrolled in a QHP through VHC.

Private facility. Any home privately owned and operated, or any home or institution supported by private or charitable funds, over which neither the state nor any of its subdivisions has supervision or control even though individuals may be boarded or cared for therein at public expense. Vermont private institutions include boarding homes, fraternal homes, religious homes, community care homes, residential care facilities, medical facilities (i.e. general hospitals) and nursing facilities licensed by the State of Vermont.

Protected Income Level (PIL). The income standard for the medically-needy Medicaid coverage groups.

Public Institution. Any institution meeting all of the following conditions:

(a) The institution is owned, maintained, or operated in whole or in part by public funds;

(b) Control is exercised, in whole or in part, by any public agency or an official or employee of that agency; and

(c) The institution furnishes shelter and care and can be termed a public institution by reason of its origin, charter, ownership, maintenance or supervision.

Qualified Health Plan (QHP). A health plan certified by Vermont's Department of Financial Regulation (DFR) and offered by Vermont Health Connect.[62]

[60] 45 CFR § 155.20. Incorporates meaning of this term given in § 1311(e)(3)(B) of the ACA.

[61] 42 CFR § 435.4.

[62] 45 CFR §§ 155.20 and 156.20. 26 CFR § 1.36B-1(c) defines the term as follows: "QHP. The term QHP has the same

QHP issuer.[63] A health insurance issuer that offers a QHP in accordance with a certification from DFR.

Qualified individual.[64] For purposes of QHP, an individual who has been determined eligible by AHS to enroll in a QHP.

Qualifying coverage in an employer-sponsored plan.[65] Coverage in an eligible employer-sponsored plan that meets the affordability and minimum-value standards specified in 26 CFR § 1.36B-2(c)(3), and described in §§ 23.02 (affordable) and 23.03 (minimum value).

Quality control (QC). A system of continuing review to measure the accuracy of eligibility decisions. Also, the name of the AHS unit that is responsible for administering quality-control functions.

Reasonable compatibility. See, § 57.00(a).

Reenroll. To restore coverage after closure.

Reinstate. To restore eligibility after cancellation or closure.

Renew. For purposes of eligibility for health benefits, to redetermine eligibility at a specified periodic interval (*e.g.*, annual renewal of eligibility).

Secure electronic interface.[66] An interface that allows for the exchange of data between information technology systems and adheres to the requirements in subpart C of 42 CFR part 433.

Self-only coverage.[67] Health insurance that covers one individual and provides coverage for essential health benefits.

Special enrollment period (SEP).[68] A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP outside of AOEPs. See, § 71.03.

Spouse. A husband, a wife or a party to a civil union according to the laws of the State of Vermont, except, for purposes of APTC/CSR, a husband or a wife if married within the meaning of 26 CFR § 1.7703-1. IRS's regulations

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meaning as in section 1301(a) of the ACA (42 USC § 18021(a)) but does not include a catastrophic plan described in section 1302(e) of the ACA (42 USC § 18022(e)."

[63] 45 CFR §§ 155.20 and 156.20.

[64] 45 CFR §§ 155.20 and 156.20.

[65] 45 CFR § 155.300.

[66] 42 CFR § 435.4.

[67] 26 CFR § 1.36B-1(l).

[68] 45 CFR § 155.20.

do not recognize parties to civil unions as “spouses.” Parties to civil unions are not permitted to file joint federal tax returns, but may qualify for APTC/CSR by filing separate tax returns.

SSI. Supplemental security income program under Title XVI of the Act.

Substantial gainful activity

(a) Work activity that is both substantial and gainful, defined as follows:

(1) Substantial work activity involves doing significant physical or mental activities. Work may be substantial even if it is done on a part-time basis or if individuals do less, get paid less or have less responsibility than when they worked before.

(2) Gainful work activity is the kind of work done for pay or profit whether or not a profit is realized.

(b) Individuals who are working with disabilities shall be exempt from the substantial gainful activity (SGA) step of the sequential evaluation of the disability determination if they otherwise meet the requirements set forth in § 8.05 for the categorically needy working disabled.

Tax filer.[69] For purposes of eligibility for a QHP with financial assistance, an individual who indicates that they expect:

(a) To file an income tax return for the benefit year;

(b) If married (within the meaning of 26 CFR § 1.7703-1), to file a joint tax return for the benefit year with their spouse (who, together with the individual, is considered the tax filer) unless the tax filer meets the exceptions criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment);

(c) That no other taxpayer will be able to claim them as a tax dependent for the benefit year; and

(d) To claim a personal exemption deduction under § 151 of the Code on their tax return for one or more applicants, who may or may not include the individual or their spouse.

Tax dependent

(a) For purposes of eligibility for MAGI-based Medicaid, see, § 28.03(a).

(b) For purposes of eligibility for a QHP with financial assistance, see, § 28.05(a).

4.00 General program rules (01/01/2024, GCR 23-082)

4.01 Receiving health benefits from another state (01/15/2017, GCR 16-094)

An individual who is receiving health benefits from another state is not eligible for health benefits in Vermont.

4.02 Rights of individuals with respect to application for and receipt of health benefits through

[69] 45 CFR § 155.300.

AHS (01/01/2024, GCR 23-082)

(a) Notice of rights and responsibilities. Policies are administered in accordance with federal and state law. Individuals will be informed of their rights and responsibilities with respect to application for and receipt of health benefits.

(b) Right to nondiscrimination and equal treatment.[70] AHS does not unlawfully discriminate on the basis of race, color, religion, national origin, disability, age, sex, gender identity, or sexual orientation in the administration of its health-benefits programs or activities.

(c) Right to confidentiality. The confidentiality of information obtained during the eligibility process is protected in accordance with federal and state laws and regulations. The use and disclosure of information concerning applicants, enrollees, and legally-liable third parties is restricted to purposes directly connected with the administration of health-benefits programs, with enrollment in a QHP or as otherwise required by law.

(d) Right to timely provision of benefits. Eligible individuals have the right to the timely provision of benefits, as defined in § 61.00.

(e) Right to information. Individuals who inquire have the right to receive information about health benefits, coverage-type requirements, and their rights and responsibilities as enrollees of health-benefits programs or as enrollees in QHPs.

(f) Right to apply. Any person, individually or through an authorized representative or legal representative has the right, and will be afforded the opportunity without delay, to apply for benefits.

(g) Right to be assisted by others

(1) The individual has the right to be represented by a legal representative.

(2) The individual has the right to be accompanied and represented by an authorized representative during the eligibility or appeal processes.

(3) Upon request by the individual, copies of all eligibility notices and all documents related to the eligibility or appeal process will be provided to the individual's authorized or legal representative.

(4) An authorized representative may file an application for health benefits or an appeal on behalf of a deceased person.

(h) Right to inspect the case file. An individual has the right to inspect information in their case file and contest the accuracy of the information.

(i) Right to appeal. An individual has the right to appeal, as provided in § 68.00.

(j) Right to interpreter services. Individuals will be informed of the availability of interpreter services. Unless the

[70] See, 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502. See, also, All Programs Rule 2000(C).

individual chooses to provide their own interpreter services, AHS will provide either telephonic or other interpreter services whenever:

(1) The individual who is seeking assistance has limited English proficiency or sensory impairment (for example, a seeing or hearing disability) and requests interpreter services; or

(2) AHS determines that such services are necessary.

4.03 Responsibilities of individuals with respect to application for and receipt of health benefits through AHS (01/01/2024, GCR 23-082)

(a) Responsibility to cooperate. An individual must cooperate in providing information necessary to establish and maintain their eligibility, and must comply with all rules and regulations, including recovery and obtaining or maintaining available health insurance.

(b) Responsibility to report changes

(1) An individual must report changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

(2) A Medicaid enrollee must report such changes within 10 days of learning of the change.

(3) Except as specified in paragraphs (b)(4) and (5) of this subsection, a QHP enrollee must report such changes within 30 days of such change.

(4) A QHP enrollee who did not request an eligibility determination for APTC or CSR, and is not receiving APTC or CSR, need not report changes that affect eligibility for health-benefits programs.

(5) An individual, or an application filer on behalf of the individual, will be allowed to report changes via the channels available for the submission of an application, as described in § 52.02.

(c) Cooperation with quality control. An individual enrolled in a health-benefits program must cooperate with any quality-control (QC) review of their case. (§ 4.05)

4.04 Case records (01/01/2024, GCR 23-082)

(a) Contents. Case records include the following information:

(1) Applications for benefits;

(2) Factual data that supports eligibility findings, including, but not limited to:

(i) Documentation of verification of information submitted and any supplementary investigation of eligibility factors;

(ii) Budgetary computations;

(iii) Eligibility decisions; and

(iv) Payment authorizations.

(3) Copies of all correspondence with and concerning individuals, including, but not limited to, notices of case decisions.

(b) Use of case information. Case information may contribute in statistical or other general terms to material needed for planning, research, and overall administration of human-services programs. Individual case information shall, however, be held in accordance with the confidentiality requirements set forth in § 4.08.

(c) Retention. Case records are retained as required by federal and state requirements for audit and/or review.

4.05 Quality-control review (01/01/2024, GCR 23-082)

(a) AHS's Quality Control (QC) Unit periodically conducts independent reviews of eligibility factors in a sampling of cases. These reviews help to ensure that program rules are clear and consistently applied and that individuals understand program requirements and give correct information in support of their applications for benefits.

(b) A random sample of active Medicaid enrollees is chosen each month for a full field review of their eligibility. Each eligibility factor must be verified with the enrollee and with collateral sources.

(c) A similar sample of negative actions (e.g., denials, closures, benefit decreases) is also chosen each month. These reviews do not usually require a contact with the individual, although the reviewer may sometimes need to check facts with the individual.

(d) When a case is selected for review, the individual must cooperate with the QC representative. Cooperation includes, but is not limited to, participation in a personal interview and the furnishing of requested information. If the individual does not cooperate, eligibility for the individual's household may be closed and the individual members may be disenrolled.

(e) When there is a discrepancy between the eligibility facts, as discovered during a QC review, and those contained within the case record, AHS will schedule an eligibility review and take action to correct errors or review the effect of the changes.

4.06 Fraud (01/15/2017, GCR 16-094)

(a) Fraud. A person commits fraud in Vermont if he or she:

(1) "[K]nowingly fails, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to the qualifications of that person to receive aid or benefits under a state or federally funded assistance program, or who knowingly fails to disclose a change in circumstances in order to obtain or continue to receive under a program aid or benefits to which he or she is not entitled or in an amount larger than that to which he or she is entitled, or who knowingly aids and abets another person in the commission of any such act . . . ;"[71] or

[71] 33 VSA § 141(a).

(2) "[K]nowingly uses, transfers, acquires, traffics, alters, forges, or possesses, or who knowingly attempts to use, transfer, acquire, traffic, alter, forge, or possess, or who knowingly aids and abets another person in the use, transfer, acquisition, traffic, alteration, forgery, or possession of a . . . certificate of eligibility for medical services, or Medicaid identification card in a manner not authorized by law . . . ."[72]

(b) Legal consequences. An individual who commits fraud may be prosecuted under Vermont law. If convicted, the individual may be fined or imprisoned or both. Action may also be taken to recover the value of benefits paid in error due to fraud.

(c) AHS's responsibilities. An individual may report suspected fraud to AHS. When AHS suspects that fraud may have been committed, it will investigate the case. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

(d) Suspected fraud. The following criteria will be used to evaluate cases of suspected fraud to determine whether they should be referred to a law enforcement agency:

(1) Does the act committed appear to be a deliberately fraudulent one?

(2) Was the omission or incorrect representation an error or result of the individual's misunderstanding of eligibility requirements or the responsibility to provide information?

(3) Did the act result from AHS omission, neglect, or error in securing or recording information?

(4) Did the individual receive prior warning from a state employee that the same or similar conduct was improper?

(e) Examples

(1) The following are examples of instances in which fraud might be suspected and referral considered:

(i) The individual accepts and continues paid employment without reporting such employment after having been clearly informed of the necessity of such notification.

(ii) The individual fails to acknowledge or report income from pensions, Social Security, or relatives when it is reasonably clear that there was a willful attempt to conceal such income.

(iii) The individual disposes of property (either real or personal) and attempts to conceal such disposal.

(iv) The individual misrepresents a material fact, such as residency status or dependent relationship or status, in order to receive benefits to which they would not otherwise be eligible.

(2) These examples are intended as a guideline; each case will be evaluated individually.

(f) Methods of investigation. Any investigation of a case of suspected fraud is pursued with the same regard for

[72] 33 VSA § 141(b).

confidentiality and protection of the legal and other rights of the individual as with a determination of eligibility.

(g) Review and documentation of investigation. Procedures will be established for review and documentation of a fraud investigation.

(h) Referral to Law Enforcement Agencies. The final decision regarding referral to a law enforcement agency shall be the responsibility of the appropriate department's commissioner.

4.07 [Reserved] (01/15/2017, GCR 16-094)

4.08 Privacy and security of personally identifiable information[73] (01/15/2019, GCR 18-060)

(a) When personally-identifiable information is collected or created for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for health-benefits programs, or determining eligibility for exemptions from the individual responsibility provisions in § 5000A of the Code, such information will be used or disclosed only to the extent such information is necessary to administer health care program functions in accordance with federal and state laws.

(b) Requirements of AHS. AHS must establish and implement privacy and security standards that are consistent with the following principles.

(1)

(i) *Individual access*. Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction*. Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency*. There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information;

(iv) *Individual choice*. Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

(v) *Collection, use, and disclosure limitations*. Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity*. Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for

[73] See generally, Social Security Act §§ 1137 and 1902(a)(7); 26 USC §§ 6103; § 1413(c)(1) and (c)(2) of the ACA; 42 CFR Part 431, Subpart F; 45 CFR § 155.260; 45 CFR § 155.280.

the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards*. Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and

(viii) *Accountability*. These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(2) Safeguards. For the purposes of implementing the principle described in paragraph (a)(1)(vii) of this subsection, AHS must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this subsection) to ensure:

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by AHS;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by § 6103(b)(2) of the Code, is kept confidential under § 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules.

(3) Monitoring. AHS must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(4) Secure interfaces. AHS must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

4.09 Use of standards and protocols for electronic transactions (01/15/2017, GCR 16-094)

(a) HIPAA administrative simplification.[74] To the extent that electronic transactions are performed with a covered entity, standards, implementation specifications, operating rules, and code sets adopted by the Secretary of HHS in 45 CFR parts 160 and 162 will be used.

[74] 45 CFR § 155.270(a).

(b) HIT enrollment standards and protocols.[75] Interoperable and secure standards and protocols developed by the Secretary of HHS in accordance with § 3021 of the PHS Act will be incorporated. Such standards and protocols will be incorporated within VHC information technology systems.

5.00 Eligibility and enrollment assistance (01/01/2027~~01/01/2026~~, GCR 26-051~~25-050~~)

5.01 Assistance offered through AHS (01/01/2026, GCR 25-050)

(a) In general.[76] AHS will provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient. Eligibility and enrollment assistance that meets the accessibility standards in paragraph (c) of this subsection is provided, and referrals are made to assistance programs in the state when available and appropriate. These functions include assistance provided directly to any individual seeking help with the application or renewal process.

(b) Assistance tools

(1) Call center.[77] A toll-free call center is provided to address the needs of individuals requesting assistance and meets the accessibility requirements outlined in paragraph (c) of this subsection. The call center will provide individuals with access to a live call center representative during the call center's published hours of operation who may assist the individuals with filing their applications, including providing information to them on their eligibility for APTC and CSR, facilitating a comparison of QHPs, and helping them complete their applications for submission to AHS.

(2) Internet website.[78] An up-to-date internet website that meets the requirements outlined in paragraph (c) of this subsection is maintained. The website:

(i) Supports applicant and enrollee activities, including accessing information on the health-benefit programs available in the state, applying for and renewing coverage and providing assistance to individuals seeking help with the application or renewal process;

(ii) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools,

[75] 45 CFR § 155.270(b).

[76] 42 CFR § 435.908; 45 CFR § 155.205(d). Note: While the consumer-assistance responsibilities of Medicaid agencies and Exchanges may be distinct, "[s]ome aspects of [the Medicaid agency's] applicant and beneficiary assistance may be integrated with the consumer assistance tools and programs of the Exchange." See, CMS "Summary of Proposed Provisions and Analysis of and Responses to Public Comments," 77 Fed. Reg. 17144, 17166 (Mar. 23, 2011). Vermont has opted to operate one health-benefits assistance call center, serving the needs of all applicants and beneficiaries of health benefits.

[77] 42 CFR § 435.908; 45 CFR § 155.205(a).

[78] Social Security Act § 1943 (42 USC § 1396w-3); 42 CFR § 435.1200(f); 45 CFR § 155.205(b).

including at a minimum:

(A) Premium and cost-sharing information;

(B) The summary of benefits and coverage established under § 2715 of the PHS Act;

(C) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by § 1302(d) of the ACA, or a catastrophic plan as defined by § 1302(e) of the ACA;

(D) The results of the enrollee satisfaction survey, as described in § 1311(c)(4) of the ACA;

(E) Beginning 2015, quality ratings assigned in accordance with § 1311(c)(3) of the ACA;

(F) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;

(G) Transparency of coverage measures reported to VHC during certification; and

(H) The provider directory made available to VHC.

(iii) Publishes the following financial information:

(A) The average costs of licensing required by VHC;

(B) Any regulatory fees required by VHC;

(C) Any payments required by VHC in addition to fees under paragraphs (b)(2)(iii)(A) and (B) of this subsection;

(D) Administrative costs of VHC; and

(E) Monies lost to waste, fraud, and abuse.

(iv) Provides individuals with information about Navigators as described in § 5.03 and other consumer assistance services, including the toll-free telephone number of the call center required in paragraph (b)(1) of this subsection.

(v) Allows for an individual to submit a single, streamlined eligibility application to AHS in accordance with § 52.02 and for AHS to make all determinations of eligibility for enrollment in a QHP and insurance affordability programs in accordance with § 58.00, through the operation of a centralized eligibility and enrollment platform.

(vi) Allows a qualified individual to select a QHP in accordance with § 71.00, and allows AHS to maintain records of all QHP enrollments through the operation of a centralized eligibility and enrollment platform.

(vii) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any APTC, premium reductions and any federal or state CSR.

(c) Accessibility[79]

(1) Information is provided in plain language and in a manner that is accessible and timely.

(2) Individuals living with disabilities will be provided with, among other things, accessible websites and auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act.

(3) For individuals with limited English proficiency, language services will be provided at no cost to the individual, including:

(i) Oral interpretation, including telephonic interpreter services;

(ii) Written translations;

(iii) Taglines in non-English languages indicating the availability of language services; and

(iv) Website translations.

(4) Individuals will be informed of the availability of the services described in this paragraph and how they may access such services.

(d) Availability of program information[80]

(1) The following information is furnished in electronic and paper formats, and orally as appropriate, to all individuals who request it:

(i) The eligibility requirements;

(ii) Available health benefits and services; and

(iii) The rights and responsibilities of individuals.

(2) Bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and understandable terms will be published in quantity and made available.

(3) Such information is provided in a manner that meets the standards in paragraph (c) of this subsection.

(e) Outreach and education.[81] Outreach and education activities that meet the standards in paragraph (c) of this subsection to educate consumers about VHC and Vermont's health-benefits programs to encourage participation will be conducted.

[79] 42 CFR § 435.905(b); 45 CFR § 155.205(c).

[80] 42 CFR § 435.905; 45 CFR § 155.205.

[81] Social Security Act § 1943 (42 USC § 1396w-3); 45 CFR § 155.205(e).

(f) Americans with Disabilities Act (ADA).[82] As required by the Americans with Disabilities Act, reasonable accommodations and modifications will be made to policies, practices, or procedures when necessary, as determined by the appropriate commissioners or their designees, to provide equal access to programs, services and activities, or when necessary to avoid discrimination on the basis of disability. An individual may appeal the commissioner's determination regarding necessity to the appropriate fair hearings entity or appeals entity in accordance with departmental regulations governing appeals and fair hearings.

(g) Non-discrimination.[83] AHS assistance programs and activities will:

(1) Comply with applicable non-discrimination statutes; and

(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

5.02 Authorized representatives[84] (01/01/2024, GCR 23-082)

(a) In general

(1) An individual may designate another person or organization to accompany, assist, and represent or to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with AHS. These include:

(i) Guardians and people with powers of attorney (§ 5.02(i)); and

(ii) Any other person of the individual's choice.

(2) AHS may permit an applicant or enrollee to authorize a representative to perform fewer than all of the activities described in paragraph (b)(1) of this subsection, provided that AHS tracks the specific permissions for each authorized representative.

(3) Except as provided in paragraph (h) of this subsection, and consistent with current state policy and practice, designation of an authorized representative must be in writing, including the individual's signature, or through another legally binding format subject to applicable authentication and data security standards.

(4) Designation will be permitted at the time of application and at other times.

(5) Legal documentation of authority to act on behalf of an individual under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the individual. In such cases AHS may recognize an individual as an authorized representative before the

[82] All Programs Rule 2030.

[83] 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502.

[84] 42 CFR §§ 435.908(b) and 435.923; 45 CFR § 155.227.

legal documentation is provided to AHS.

(6) When an individual dies before applying for retroactive Medicaid coverage, the administrator or executor of the individual's estate, a surviving relative or responsible person may act as the individual's representative.

(b) Scope of authority

(1) Representatives may be authorized to do any or all of the following:

(i) Assist the individual in completing and submitting any health-benefits application, verification, or other documentation with AHS;

(ii) Give and receive information regarding the individual's application or enrollment;

(iii) Sign an application on the individual's behalf;

(iv) Receive copies of the individual's notices and other communications. A person who receives authority to only receive copies of communications is referred to as an "alternate reporter";

(v) Request a fair hearing or file a grievance; and

(vi) Act on behalf of the individual in any other matters with AHS.

(2) The kinds of information that may be shared may include the following:

(i) Information or proofs needed to complete the application or redetermination of eligibility;

(ii) The status of the application including the program or programs the household members are enrolled in and the effective dates of enrollment;

(iii) The reason the individual or household is not eligible for a benefit, if the application is denied or benefits end; and

(iv) The effective date of redetermination and any outstanding information or verifications needed to complete a redetermination.

(c) Duration of authorization

(1) The power to act as an authorized representative is valid with AHS until:

(i) The individual modifies the authorization or notifies AHS, using one of the methods available for the submission of an application, as described in § 52.02(b)(2), that the representative is no longer authorized to act on their behalf;

(ii) The authorized representative informs AHS that they no longer are acting in such capacity; or

(iii) There is a change in the legal authority upon which the individual or organization's authority was based.

(2) Any notification described in (c)(1) of this subsection, except as stated in (c)(1)(i), must be in writing and should include the individual's or authorized representative's signature as appropriate.

(d) Duties of the authorized representative. The authorized representative:

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b) of this subsection, to the same extent as the individual they represent; and

(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual provided.

(e) Condition of representation

(1) The authorized representative must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by AHS.

(2) When an organization is designated as an authorized representative, as a condition of serving, staff members or volunteers of that organization must sign an agreement that they will adhere to the regulations in § 4.08 (relating to confidentiality of information), federal regulations relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

(f) Form of authorization. For purposes of this subsection, electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission will be accepted. Designations of authorized representatives will be accepted through all of the modalities described in § 52.02(b).

(g) Disclosures. The authorization form or the AHS call center representative (if the authorization is made over the telephone) shall advise that:

(1) The individual need not give permission to share information.

(2) If the individual decides not to give permission, that will not affect eligibility for, or enrollment in, benefits;

(3) If the individual does not give permission, the information will not be released unless the law otherwise allows it;

(4) AHS is not responsible for what an unrelated authorized representative does with the individual's information after it is shared pursuant to a valid authorization;

(5) The individual may change or stop this authorization at any time by notifying AHS by telephone or in writing. However, doing so will not affect previously shared information;

(6) If the individual does not change or stop the authorization, it will remain in effect as long as the individual (or household) continues to receive health-care benefits; and

(7) The individual will be provided with a copy of the authorization upon request.

(h) Minors and incapacitated adults.[85] If the individual is a minor or an incapacitated adult, no authorization is required; someone acting responsibly for the individual may assist in the application process or during a redetermination of eligibility. Such person may also sign the initial application on the applicant's behalf.

(i) Judicially-appointed legal guardian or representative.[86] Upon presentment of a valid document of appointment, a judicially-appointed legal guardian or representative may act on an individual's behalf.

5.03 Navigator program (01/01/2027~~10/01/2021~~, GCR 26-051~~20-001~~)

(a) General requirements.[87] AHS conducts a Navigator program consistent with this subsection through which it awards grants to eligible entities to perform the functions of navigator organizations, and certifies individuals as Navigators. The functions of navigator organizations include providing assistance to individuals and employers with enrollment in Medicaid programs and qualified health plans.

(b) Standards.[88] AHS maintains and publicly disseminates:

(1) A set of standards, to be met by all entities and individuals to be awarded Navigator grants, designed to prevent, minimize, and mitigate any conflicts of interest, financial or otherwise, that may exist for an entity to be awarded a Navigator grant, and to ensure that all entities and individuals carrying out Navigator functions have appropriate integrity; and

(2) A set of training standards, to be met by all entities and individuals carrying out Navigator functions under the terms of a Navigator grant, to ensure expertise in:

(i) The needs of underserved and vulnerable populations;

(ii) Eligibility and enrollment rules and procedures;

(iii) Benefits rules and regulations governing all health-benefits programs and QHPs offered in the state;

(iv) The range of QHP options and health-benefits programs;

(v) The privacy and security standards applicable under § 4.08;

(vi) The process of filing eligibility appeals;

(vii) General concepts regarding exemptions from the requirement to maintain minimum essential

[85] 42 CFR § 435.907(a); 45 CFR § 155.20.

[86] All Programs Rule 2014.

[87] 45 CFR § 155.210(a); 33 VSA § 1807.

[88] 45 CFR §§ 155.205(d) and 155.210(b).

coverage and from the individual shared responsibility payment, including the application process for exemptions, and IRS resources and exemptions;

(viii) The premium tax credit reconciliation process and IRS resources on this process;

(ix) Basic concepts and rights related to health coverage and how to use it; and

(x) Providing referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice.

(c) Entities and individuals eligible to be a Navigator.[89] To receive a Navigator grant, an entity must:

(1) Be capable of carrying out at least those duties described in paragraph (f) of this subsection;

(2) Demonstrate to AHS that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

(3) Meet any licensing, certification or other standards prescribed by the state or AHS;

(4) Not have a conflict of interest during the term as Navigator; and

(5) Comply with the privacy and security standards applicable under § 4.08.

(d) Prohibition on Navigator conduct.[90] A Navigator must not:

(1) Be a health insurance issuer or issuer of stop loss insurance;

(2) Be a subsidiary of a health insurance issuer or issuer of stop loss insurance;

(3) Be an association that includes members of, or lobbies on behalf of, the insurance industry;

(4) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or a non-QHP;

(5) Charge any applicant or enrollee, or request or receive any form of remuneration from or on behalf of an individual applicant or enrollee, for application or other assistance related to Navigator duties;

(6) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph, the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third

[89] 45 CFR § 155.210(c).

[90] 45 CFR § 155.210(d).

party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive application assistance, such as, but not limited to, travel or postage expenses;

(7) Use AHS funds to purchase gifts or gift cards, or promotional items that market or promote the products or services of a third party, that would be provided to any applicant or potential enrollee;

(8) Solicit any individual for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling an individual to provide application or enrollment assistance without the individual initiating the contact, unless the individual has a pre-existing relationship with the individual Navigator or Navigator entity and other applicable state and federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling an individual; or

(9) Initiate any telephone call to an individual using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual Navigator or Navigator entity has a relationship with the individual and so long as other applicable state and federal laws are otherwise complied with.

(e) Conflict-of-interest standards.[91] In addition to prohibited conduct in (d) of this subsection, the following standards apply to Navigators:

(1) All Navigator entities must submit to VHC a written attestation that the Navigator, including the Navigator's staff, complies with (d)(1).

(2) All Navigator entities must submit to VHC a written plan to remain free of conflicts of interest during the term as a Navigator.

(3) All Navigator entities, including the Navigator's staff, must provide information to consumers about the full range of QHP options and health-benefits programs for which they are eligible.

(4) All Navigator entities, including the Navigator's staff, must disclose to VHC and, in plain language, to each consumer who receives application assistance from the Navigator:

(i) Any lines of insurance business, not covered by the restrictions on participation and prohibitions on conduct in (d) of this subsection, which the Navigator intends to sell while carrying out the consumer assistance functions;

(ii) Any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

(iii) For Navigator staff, any existing employment relationships, or any former employment relationships within the last 5 years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or

[91] 45 CFR § 155.215(a).

issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance.

(f) Duties of a Navigator.[92] An entity that serves as a Navigator must carry out at least the following duties:

(1) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about VHC;

(2) Conduct public education activities to raise awareness of the availability of qualified health benefit plans;

(3) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, other public health-benefits programs, or QHP;

(4) Provide information and services in a fair, accurate and impartial manner, which includes providing information that assists individuals with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping individuals make informed decisions during the health coverage selection process. Such information must acknowledge other health programs;

(5) Distribute fair and impartial information concerning enrollment in QHPs and concerning the availability of premium tax credits, premium reductions, and cost-sharing reductions;

(6) Facilitate selection of a QHP or public health-benefits program such as Medicaid, Dr. Dynasaur, or VPharm;

(7) Provide referrals to any applicable office of health insurance consumer assistance, health insurance ombudsman, or any other appropriate state agency or agencies, for any individual with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage;

(8) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by VHC, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act;

(9) Ensure that individuals:

(i) Are informed, prior to receiving assistance, of the functions and responsibilities of Navigators, including that Navigators are not acting as tax advisers or attorneys when providing assistance as Navigators and cannot provide tax or legal advice within their capacity as Navigators;

(ii) Provide authorization in a form and manner as determined by AHS prior to a Navigator's obtaining access to an individual's personally identifiable information, and that the Navigator maintains a record of the authorization provided in a form and manner as determined by AHS. AHS will establish

[92] 45 CFR § 155.210(e); 33 VSA § 1807.

a reasonable retention period for maintaining these records; and

(iii) May revoke at any time the authorization provided to a Navigator.

(10) Maintain a physical presence in the service area, so that face-to-face assistance can be provided to applicants and enrollees;~~.~~

(11) Provide targeted assistance to serve underserved or vulnerable populations, as identified by AHS;~~.~~

(12) Provide information and assistance with the following topics:

(i) Understanding the process of filing eligibility appeals;

(ii) Understanding ~~and applying for exemptions from the individual shared responsibility payment, understanding~~ the availability of exemptions from the requirement to maintain minimum essential coverage ~~and from the individual shared responsibility payment~~ that are claimed through the federal government~~tax filing process~~ and how to claim them, and understanding the availability of ~~IRS~~ resources on this topic;

(iii) The premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;

(iv) Understanding basic concepts and rights related to health coverage and how to use it; and

(v) Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice.

~~(v)~~(13) Provide information and services to any member of the public seeking eligibility and enrollment assistance from a Navigator.

(g) Funding for Navigator grants. Funding for navigator grants may not be from Federal funds received by the state to establish VHC.

5.04 Brokers (01/01/2027~~01/01/2026~~, GCR 26-0512~~5-050~~)

(a) General rule.[93] A broker may:

(1) Facilitate enrollment of an individual, employer, or employee in any QHP as soon as the QHP is offered;

(2) Subject to paragraphs (b) and (c) of this subsection, assist an individual in applying for a QHP with financial assistance; and

(3) Subject to paragraphs (b) and (c) of this subsection assist an employee or an employer in enrolling in any QHP.

[93] 45 CFR § 155.220(a); 33 VSA § 1805(17).

(b) Agreement.[94] Prior to enrolling a qualified individual, employee, or employer in a QHP through VHC, or assisting an individual in applying for a QHP with financial assistance, a broker must have an executed agreement with AHS, and must comply with the terms of that agreement, which includes at least the following requirements:

(1) Registering with AHS in advance of assisting a qualified individual, employee or employer, enrolling in QHPs through VHC;

(2) Receiving training in the range of QHP options and health-benefit programs;

(3) Complying with AHS's privacy and security standards adopted consistent with § 4.08; ~~and~~

(4) Maintaining a physical presence in the service area, so that face-to-face assistance can be provided to applicants and enrollees; and~~.~~

~~(4)~~(5) Providing assistance in a manner consistent with professional standards for licensed Vermont insurance producers.

(c) Payment mechanisms.[95] A broker who facilitates enrollment of an individual, employer, or employee in any QHP may charge a reasonable fee for assisting with the enrollment of qualified individuals and qualified employers in any QHP offered through VHC for which the individual or employer is eligible; and assisting a qualified individual in applying for financial assistance for a QHP purchased through VHC. A QHP issuer may not pay any part of a broker fee.[96]

(d) Web broker prohibition. Vermont does not permit a broker or any entity that is not a QHP issuer to develop and host a non-exchange website to assist consumers with direct enrollment in a QHP offered through VHC.[97]

5.05 Certified application counselors[98] (01/01/2027~~01/01/2024~~, GCR 26-051~~23-082~~)

(a) In general. AHS certifies staff and volunteers of state-partner organizations to act as application counselors, authorized to provide assistance to individuals with the application process and during renewal of eligibility.

(b) Certification

(1) Application counselors are certified by AHS to provide assistance at application and renewal with respect to one, some, or all of the permitted assistance activities, and enter into certification agreements with

[94] 45 CFR § 155.220(d); 33 VSA § 1805(17).

[95] 33 VSA § 1805(17).

[96] 8 VSA § 4022.

[97] 45 CFR § 155.20. See, also, 45 CFR §§ 155.220 and 155.221.

[98] 42 CFR § 435.908; 45 CFR § 155.225.

AHS.

(2) To be certified, application counselors must:

(i) Be authorized and registered by AHS to provide assistance at application and renewal;

(ii) Be effectively trained in the eligibility and benefits rules and regulations governing enrollment in a QHP and all health-benefits programs operated in Vermont;

(iii) Have successfully completed the required training and received a passing score on the certification examination;

(iv) Disclose to AHS and potential applicants any relationships the certified application counselor or sponsoring agency has with QHPs or insurance affordability programs, or other potential conflicts of interest;

(v) Comply with AHS's privacy and security standards adopted consistent with § 4.08 and applicable authentication and data security standards;

(vi) Agree to act in the best interest of the applicants assisted;

(vii) Either directly or through an appropriate referral to the VHC call center, provide information in a manner that is accessible to individuals with disabilities, as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. § 12101 *et seq*. and § 504 of the Rehabilitation Act, as amended, 29 USC § 794; and

(viii) Be recertified on at least an annual basis after successfully completing recertification training as required by AHS.

(c) Withdrawal of certification. AHS will establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization, when it finds noncompliance with the terms and conditions of the application counselor agreement.

(d) Duties. Certified application counselors must carry out the following duties as a condition of their certification~~are certified to~~:

(1) Provide information to individuals and employees about the full range of QHP options and health-benefits programs for which they are eligible, which includes providing fair, impartial and accurate information that assists individuals with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping individuals make informed decisions during the health coverage selection process;

(2) Assist individuals and employees to apply for coverage in a QHP through VHC and for health-benefits programs; ~~and~~

(3) Help to facilitate enrollment of eligible individuals in QHPs and health-benefits programs; and~~.~~

~~(3)~~(4) Provide information and services to any member of the public seeking eligibility and enrollment

assistance or refer them to another source of eligibility and enrollment assistance.

(e) Availability of information; authorization. AHS must establish procedures to ensure that:

(1) Individuals are informed, prior to receiving assistance, of the functions and responsibilities of certified application counselors, including that certified application counselors are not acting as tax advisers or attorneys when providing assistance as certified application counselors and cannot provide tax or legal advice within their capacity as certified application counselors;

(2) Individuals are able to provide authorization in a form and manner as determined by AHS prior to a certified application counselor obtaining access to personally identifiable information about the individual related to the individual's application for, or renewal of, health benefits, and that the organization or certified application counselor maintains a record of the authorization in a form and manner as determined by AHS. AHS will establish a reasonable retention period for maintaining these records;

(3) AHS does not disclose confidential individual information to an application counselor unless the individual has authorized the application counselor to receive such information; and

(4) Individuals may revoke at any time the authorization provided the certified application counselor.

(f) No charge for services. Application counselors may not:

(1) Impose any charge on individuals for application or other assistance related to VHC;

(2) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individual in a QHP or a non-QHP;

(3) Provide to an applicant or potential enrollee gifts of any value as inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph, the term gifts includes gift items, gift cards, cash cards, cash and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive application assistance, such as, but not limited to, travel or postage expenses;

(4) Solicit any individual for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling an individual to provide application or enrollment assistance without the individual initiating the contact, unless the individual has a pre-existing relationship with the individual certified application counselor or designated organization and other applicable state and federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling an individual; or

(5) Initiate any telephone call to an individual using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual certified application counselor or designated organization has a relationship with the individual and so long as other applicable state and federal laws are otherwise complied with.

(g) Non-discrimination and organizations receiving federal funds to provide services to defined populations.[99] Notwithstanding the non-discrimination provisions of § 5.01(g), an organization that receives federal funds to provide services to a defined population under the terms of federal legal authorities that participates in the certified application counselor program may limit its provision of certified application counselor services to the same defined population, but must comply with § 5.01(g) with respect to the provision of certified application counselor services to that defined population, If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the individual to other AHS-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with § 5.01(g).

[99] 45 CFR § 155.120(c)(2).

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Part One
General Provisions and Definitions

1.00 Administration of health benefits (01/15/2017, GCR 16-094)

The Agency of Human Services (AHS) was created in 1969 to serve as the umbrella organization for all human-service activities within state government. It is the Single State Agency for Medicaid purposes and the adopting authority for this rule.

2.00 General description of health benefits in Vermont (subject to specific criteria in subsequent sections) (01/01/2024, GCR 23-082)

2.01 Types of health benefits (01/15/2017, GCR 16-094)

(a) In general. The state offers several types of health benefits, including:

- Medicaid;
- Children's Health Insurance Program (CHIP);
- Enrollment in a Qualified Health Plan (QHP) with financial assistance.

The benefits for which a person is eligible is determined based on the individual's income, resources (in specified cases), and circumstances as covered in succeeding sections.

(b) Benefit choice. Except as may be otherwise restricted, an individual may select the particular health benefit or benefits that they wish to be considered for. In the absence of such a selection, AHS will determine an individual's eligibility for the most advantageous benefit that they qualify for.

(c) Redetermination of eligibility. If an individual becomes ineligible for one benefit, AHS will determine eligibility for the next most advantageous benefit that they then qualify for.

2.02 Medicaid (01/01/2024, GCR 23-082)

(a) Overview of the Medicaid Program. The Medicaid program is authorized in Title XIX of the Social Security Act (the Act).

(b) Medicaid eligibility. Vermont provides Medicaid to those who meet the requirements of one of three eligibility groups:

- Mandatory categorically needy;
- Optional categorically needy; and
- Medically needy.

To be eligible for federal funds, states are required to provide Medicaid coverage for certain groups of individuals. These groups–the mandatory categorically needy–derive from the historic ties to programs that provided federally-assisted income-maintenance payments (*e.g.*, SSI and Aid to Families with Dependent Children). States are also required to provide Medicaid to related groups not receiving cash payments.

States also have the option of providing Medicaid coverage for other "categorically related" groups. These optional groups share characteristics of the mandatory groups (that is, they fall within defined categories), but the eligibility criteria are somewhat more liberally defined.

The medically-needy option allows states to extend Medicaid eligibility to additional groups of people. These individuals would be eligible for Medicaid under one of the mandatory or optional groups, except that they do not meet the income or resource standards for those groups. Individuals may qualify immediately or may "spend down" by incurring medical expenses greater than the amount by which their income or resources exceed their state's medically-needy standards.[1]

(c) Vermont's Medicaid Program. The Vermont Medicaid program covers all mandatory categories of enrollees. It also offers all mandatory services—general hospital inpatient; outpatient hospital and rural health clinics; other laboratory and x-ray; nursing facility, Early Periodic Screening, Diagnosis and Treatment (EPSDT), and family planning services and supplies; physician's services and medical and surgical services of a dentist; home health services; and nurse-midwife and nurse practitioner services.[2] Vermont includes certain, but not all, optional categories of enrollees. Vermont has also elected to cover certain, but not all, optional services for which federal financial participation is available. It also operates health care programs permitted by research demonstration waiver authority under § 1115 of the Social Security Act.

Vermont is authorized to establish reasonable standards, consistent with the objectives of the Medicaid statute, for determining the extent of coverage in the optional categories[3] based on such criteria as medical necessity or utilization control.[4] In establishing such standards for coverage, Vermont ensures that the amount, duration, and scope of coverage are reasonably sufficient to achieve the purpose of the service.[5] Vermont may not limit services based upon diagnosis, type of illness, or condition.[6]

2.03 Children's Health Insurance Program (CHIP) (01/01/2018, GCR 17-043)

(a) In general. CHIP (known from its inception until March 2009 as the State Children's Health Insurance Program, or SCHIP) is authorized by Title XXI of the Social Security Act.

(b) Vermont CHIP. Vermont utilizes CHIP to provide health coverage to uninsured children with household incomes above 237% and at or below 312% of the federal poverty level (FPL). CHIP is part of the coverage array known as "Dr. Dynasaur." All of the provisions in this rule that apply to the "child" Medicaid coverage

[1] In Vermont, the Medically Needy Income Level is known as the "Protected Income Level," or "PIL."

[2] For rules that govern Medicaid covered services, refer to Health Care Administrative Rules (HCAR).

[3] 42 USC § 1396a(a)(17).

[4] 42 CFR § 440.230(d).

[5] 42 CFR § 440.230(b).

[6] 42 CFR § 440.230(c).

group (§ 7.03(a)(3)) apply with equal effect to an individual who is enrolled in CHIP.

2.04 The Health Benefits Exchange (01/15/2019, GCR 18-060)

(a) In general. Vermont has elected to establish and operate its own Exchange. Vermont Act No. 48 of 2011, "An act relating to a universal and unified health system," established the Vermont health benefit exchange (Vermont Health Connect, VHC). The purpose of VHC is to facilitate the purchase of affordable, qualified health benefit plans by individuals, and small employers in the merged individual and small group markets; and later in the large group market in Vermont in order to reduce the number of uninsured and underinsured; to reduce disruption when individuals lose employer-based insurance; to reduce administrative costs in the insurance market; to contain costs; to promote health, prevention, and healthy lifestyles by individuals; and to improve quality of health care.

Qualified health plans (QHPs) must provide a comprehensive set of services (essential health benefits), meet specific standards for actuarial value and the limitation of cost-sharing.

Additionally, catastrophic plans are available to certain individuals.

The state will certify health plans offered through VHC on an annual basis.

(b) Financial assistance through VHC. Eligible individuals who purchase insurance through VHC may receive federal premium tax credits and Vermont premium reductions. Some also qualify for federal and Vermont cost-sharing reductions (CSR).

Federal premium tax credits are available to eligible individuals and families with incomes up to 400 percent of the FPL to purchase insurance through VHC.[7]

The state will supplement the federal premium tax credits with premium reductions for individuals and families with income at or below 300% of the federal poverty level.

In addition to premium subsidies, eligible individuals receive federal and state CSRs for silver level plans (see level of coverage in § 3.00) and in other limited circumstances. These subsidies reduce the cost-sharing amounts and annual cost-sharing limits and have the effect of increasing the actuarial value of the plan.

Modified adjusted gross income (MAGI) is used to determine eligibility for federal and state premium subsidies and CSRs. In order to be eligible for federal CSR, state premium reductions and state CSR, the individual must be eligible for federal premium tax credits.[8]

(c) Administrative Requirements. Federal health-care regulations contain a number of provisions aimed at the administration of the health-benefits eligibility-determination process. These provisions are intended to promote administratively-efficient, streamlined, and coordinated eligibility business processes.

[7] 26 CFR § 1.36B-2.

[8] See, 26 CFR § 1.36B-2.

2.05 Administration of eligibility for health benefits (01-01-2024, GCR 23-082)

(a) AHS administers eligibility for the state's health-benefits programs and for enrollment in a QHP in accordance with applicable provisions of federal and state law and regulations.

(b) The eligibility determination process is administered such that:

(1) Individual dignity and self-respect are maintained;

(2) The constitutional and other legal rights of individuals are respected;

(3) Practices do not violate the individual's privacy or dignity or harass the individual in any way;

(4) Disclosure of information concerning applicants or enrollees is limited to purposes directly connected with the administration of the applicable health-benefits program or with enrollment in a QHP or as otherwise required by law;

(5) Each individual who wishes to do so is given an opportunity to apply or reapply for benefits without delay;

(6) Prompt action is taken on each application and reapplication and individuals are notified in writing of the decision on the application;

(7) Decisions are based on recorded information showing either that all pertinent eligibility requirements are met or that one or more requirements are not met;

(8) Benefits are given promptly and continue regularly to all eligible individuals until they are found to be ineligible;

(9) Eligibility is redetermined when circumstances change or at the time of renewal, in accordance with the same principles as initial application;

(10) Individuals are the primary sources of information about their eligibility;

(11) Individuals are informed of their responsibility to furnish complete and accurate information, including prompt notification of changes affecting their eligibility or amount of aid or benefits, and of the penalties for willful misrepresentation to obtain benefits to which they are not entitled;

(12) Individuals are helped to obtain needed information; and

(13) Verification of conditions of eligibility are limited to what is reasonably necessary to assure that expenditures under a health-benefits program are legal, in accordance with federal and state law and regulations.

(c) Application of these principles in specific areas is covered in succeeding sections.

3.00 Definitions and use of terms (01/01/2027, GCR 26-051)

As used in this rule:

Adjusted monthly premium.[9] The premium an insurer charges for the applicable benchmark plan (ABP) to cover all members of the tax filer's coverage family.

Advance payment of the premium tax credit (APTC).[10] The payment of premium tax credits specified in section 36B of the Internal Revenue Code that are provided on an advance basis on behalf of an eligible individual enrolled in a QHP through VHC and paid directly to the QHP issuer.

Affordable Care Act (ACA).[11] The Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111-152), as amended by the Three Percent Withholding Repeal and Job Creation Act (Pub. L. 112-56).

Aid to the Aged, Blind, or Disabled (AABD).[12] Vermont's supplemental security income (SSI) state supplement program.

Alternate reporter. A person who is authorized to receive either original notifications or copies of such notifications on behalf of an individual. See, § 5.02(b)(1)(iv).

Annual open enrollment period (AOEP).[13] The period each year during which a qualified individual may enroll or change coverage in a QHP. See, § 71.02.

Applicable benchmark plan (ABP).[14] See, § 60.06.

Applicant[15]

(a) An individual seeking eligibility for health benefits for themselves through an application submission.

(b) An employer or employee seeking eligibility for enrollment in a QHP, where applicable.

Application.[16] A single, streamlined application for health benefits, submitted by or on behalf of an applicant. For determining eligibility on a basis other than the applicable MAGI standard, the single, streamlined application may be

[9] 26 CFR § 1.36B-3(e).

[10] 42 CFR § 435.4; 45 CFR § 155.20; § 36B of the Code (as added by § 1401 of the ACA); 33 VSA § 1812.

[11] 26 CFR § 1.36B-1(j); 42 CFR § 435.4; 45 CFR § 155.20.

[12] 33 VSA § 1301 et seq.; AABD Rule 2700 et seq.

[13] 45 CFR § 155.20.

[14] 26 CFR § 1.36B-3(f).

[15] 42 CFR § 435.4; 45 CFR §§ 155.20 and 156.20.

[16] 42 CFR § 435.4; 45 CFR § 155.410(a).

supplemented with form(s) to collect additional information needed, or an appropriate alternative application may be used.

Application date

(a) The day the application is received by AHS, if it is received on a business day; or

(b) The first business day after the application is received, if it is received on a day other than a business day.

If an application is supplemented with form(s) to collect additional information, including the use of an alternative application, the application date is the date the initial application is received by AHS.

Application filer[17]

(a) An applicant;

(b) An adult who is in the applicant's household;

(c) An authorized representative of the applicant; or

(d) If the applicant is a minor or incapacitated, someone acting responsibly for the applicant.

Approve. For purposes of eligibility for health benefits, to determine that an individual is eligible.

Authorized representative. A person or entity designated by an individual to act responsibly in assisting the individual with their application, renewal of eligibility and other ongoing communications. See, § 5.02.

Benefit year (or taxable year).[18] A calendar year for which a health plan provides coverage for health benefits.

Broker.[19] A person or entity licensed by the state as a broker or insurance producer.

Business day. Any day during which state offices are open to serve the public.

Caretaker relative[20]

(a) A relative of a dependent child (as defined in this § 3.00) by blood, adoption, or marriage, with whom the child is living, who assumes primary responsibility for the child's care (as may, but is not required to, be indicated by

[17] 42 CFR § 435.907; 45 CFR § 155.20.

[18] 45 CFR §§ 155.20 and 156.20. The Treasury regulations employ the term "taxable year." The Internal Revenue Code defines the "benefit year" as "the calendar year, or the fiscal year ending during such calendar year, upon the basis of which the taxable income is computed under subtitle A. . . ." 26 USC § 7701(a)(23). For most individuals, the benefit year is the calendar year, and thus, synonymous with the Exchange regulation's definition of "benefit year."

[19] 45 CFR § 155.20.

[20] 42 CFR § 435.4.

claiming the child as a tax dependent for Federal income tax purposes).

(b) As used in this definition, a "relative" is the child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece. The term relative includes:

(1) An individual connected to the child by blood, including half-blood;

(2) An individual of preceding generations denoted by grand, great, or great-great;

(3) The spouse or civil-union partner of such relative, even after the marriage or union is terminated by death or dissolution; and

(4) An adult not related to the child by blood, adoption, or marriage, but who lives with the child and has primary responsibility for the child's care.

Case file. The permanent collection of documents and information required to determine eligibility and to provide benefits to individuals.

Categorically needy.[21] Families and children; aged, blind, or disabled individuals; and pregnant women, described under subparts B and C of 42 CFR part 435 who are eligible for Medicaid. Subpart B describes the mandatory eligibility groups who, generally, are receiving or are deemed to be receiving cash assistance under the Act. These mandatory groups are specified in §§ 1902(a)(10)(A)(i),1902(e),1902(f), and 1928 of the Act. Subpart C describes the optional eligibility groups of individuals who, generally, meet the categorical requirements or income or resource requirements that are the same as or less restrictive than those of the cash assistance programs and who are not receiving cash payments. These optional groups are specified in §§ 1902(a)(10)(A)(ii),1902(e), and 1902(f) of the Act.

Catastrophic plan.[22] A health plan available to an individual up to age 30 or to an individual who is exempt from the mandate to purchase coverage that:

(a) Meets all applicable requirements for health insurance coverage in the individual market and is offered only in the individual market;

(b) Does not provide a bronze, silver, gold, or platinum level of coverage; and

(c) Provides coverage of essential health benefits once the annual limitation on cost sharing is reached, with the following exceptions:

(1) A catastrophic plan must provide coverage for at least three primary-care visits per year before reaching the deductible.

(2) A catastrophic plan may not impose any cost-sharing requirements for preventive services, in accordance

[21] 42 CFR § 435.4.

[22] 45 CFR § 156.155.

with § 2713 of the Public Health Service Act.

Certified application counselors. Staff and volunteers of organizations who are authorized and registered by AHS to provide assistance to individuals with the application process and during renewal of eligibility. See, § 5.05

Close. For purposes of eligibility for health benefits, to determine that an enrollee is no longer eligible to receive health benefits.

Code. Internal Revenue Code.

Community maintenance allowance. See, § 24.04(c).

Community spouse (CS). For purposes of Medicaid, the spouse of an institutionalized individual who is not living in a medical institution or a nursing facility. An individual is considered a community spouse even when receiving Medicaid coverage of long-term care services and supports in a home and community-based setting if they are the spouse of an individual who is also receiving Medicaid coverage of long-term care services and supports.

Cost sharing.[23] For purposes of QHP, any expenditure required by or on behalf of an individual with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance-billing amounts for non-network providers, and spending for non-covered services.

Cost-sharing reductions (CSR).[24] Reductions in cost sharing (as defined in this § 3.00) for an individual who is enrolled in a silver-level QHP or for an individual who is an Indian enrolled in a QHP.

Couple. Two individuals who are married to each other or are parties to a civil union, according to the laws of the State of Vermont, except, for purposes of APTC/CSR, two individuals who are married to each other within the meaning of 26 CFR § 1.7703-1. IRS's regulations do not recognize parties to civil unions as married couples. Couples in civil unions are not permitted to file joint federal tax returns, but may qualify for APTC/CSR by filing separate tax returns.

Coverage family.[25] See, § 60.02(b).

Coverage group.[26] Category of Medicaid eligibility, defined by particular categorical, financial, and nonfinancial criteria.

Coverage island. A discrete period of Medicaid coverage that is available in certain defined circumstances. See, § 70.02(d).

Date of application. See definition of "application date" in this § 3.00.

[23] 45 CFR §§ 155.20 and 156.20.

[24] 45 CFR §§ 155.20 and 156.20; 33 VSA § 1812.

[25] 26 CFR § 1.36B-3(b)(1).

[26] 42 CFR § 435.10(b).

Day. A calendar day unless a business day is specified.

Deny. For purposes of eligibility for health benefits, to determine that an applicant is ineligible.

Dependent child.[27] For purposes of Medicaid eligibility, an individual who is:

(a) Under the age of 18; or

(b) Age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training.

Disability

(a) Individual age 18 and older. An individual age 18 and older is considered disabled if they are unable to engage in any substantial gainful activity because of any medically-determinable physical or mental impairment, or combination of impairments, that can be expected to result in death, or has lasted or can be expected to last for a continuous period of not fewer than 12 months. To meet this definition, an individual must have a severe impairment, which makes them unable to do their previous work or any other substantial gainful activity that exists in the national economy. To determine whether an individual is able to do any other work, AHS considers their residual functional capacity, age, education, and work experience.

(b) Individual under age 18. An individual under age 18 is considered disabled if they have a medically-determinable physical or mental impairment, or combination of impairments, resulting in marked and severe functional limitations, that can be expected to result in death or that have lasted or can be expected to last for at least 12 consecutive months. An individual under age 18 who engages in substantial gainful activity may not be considered disabled.

Disenroll. To end coverage.

Dr. Dynasaur. The collection of programs that provide health benefits to children under age 19 in the group defined in § 7.03(a)(3) and pregnant women in the group defined in § 7.03(a)(2).

Electronic account.[28] An electronic file that includes all information collected and generated by the state regarding each individual's health-benefits eligibility and enrollment, including all documentation required under § 4.04 and including information collected or generated as part of a fair hearing process conducted with regard to health-benefits eligibility and enrollment.

Eligible. The status of an individual determined to meet all financial and nonfinancial qualifications for health benefits.

Eligible employer-sponsored plan[29]

(a) With respect to an employee, a group health plan or group health insurance coverage offered by an employer

[27] 42 CFR § 435.4.

[28] 42 CFR §§ 435.4 and 435.914.

[29] 26 CFR § 1.36-2(c)(3)(i); 26 USC § 5000A(f)(2).

to the employee which is:

(1) A governmental plan (within the meaning of § 2791(d)(8) of the Public Health Service (PHS) Act); or

(2) Any other plan or coverage offered in the small or large group market within a state.

(b) This term also includes a grandfathered health plan[30] offered in a group market.

Eligibility determination.[31] An approval or denial of eligibility as well as a renewal or termination of eligibility.

Eligibility process. Activities conducted for the purposes of determining, redetermining, and maintaining the eligibility of an individual.

Employer contributions.[32] Any financial contributions toward an employer-sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enroll. For purposes of eligibility for health benefits, to initiate coverage for an approved individual.

Enrollee.[33] An individual who has been approved and is currently receiving health benefits. The term “enrollee” includes the term “beneficiary,’ which is an individual who has been determined eligible for, and is currently receiving, Medicaid.

Exchange (Vermont Health Connect (VHC)).[34] A state-managed entity through which individuals, qualified employees, and small businesses can compare, shop for, purchase, and enroll in QHPs; and individuals can apply for and enroll in health-benefits programs. In Vermont, the Exchange is known as Vermont Health Connect (VHC).

Exchange service area.[35] The area in which the Exchange (in Vermont, VHC) is certified to operate.

Family coverage.[36] Health insurance that covers more than one individual and provides coverage for essential health benefits.

[30] 26 USC § 5000A(f)(1)(D).

[31] 42 CFR § 435.4. See, also, 42 CFR §§ 435.911 and 435.916; 45 CFR § 155.302.

[32] 45 CFR § 155.20.

[33] 42 CFR § 435.4.

[34] 26 CFR § 1.36B-1(k); 45 CFR § 155.20. There will be a single “service area” in Vermont, for both Medicaid and QHP enrollment.

[35] 45 CFR § 155.20.

[36] 26 CFR § 1.36B-1(m).

Family size. See, § 28.02(a).

Federal poverty level (FPL).[37] The poverty guidelines most recently published in the Federal Register by the Secretary of HHS under the authority of 42 USC § 9902(2), as in effect for the applicable budget period used to determine an individual's income eligibility for means-tested health benefits.

Financial responsibility group. For purposes of MABD, the individuals whose income or resources are considered when determining eligibility for a Medicaid group (defined below). See § 29.03 for rules on the formation of the financial responsibility group for MABD eligibility purposes.

Grace period. The period of time during which an enrollee who has failed to pay all outstanding premiums remains enrolled in coverage, with or without pended claims.

Grandfathered health plan coverage.[38] Coverage provided by a group health plan, or a group or individual health insurance issuer, in which an individual was enrolled on March 23, 2010 (for as long as it maintains that status under federal criteria).

Group health plan.[39] An employee welfare benefit plan to the extent that the plan provides medical care (including items and services paid for as medical care) to employees (including both current and former employees) or their dependents (as defined under the terms of the plan) directly or through insurance, reimbursement, or otherwise.

Health-benefits program.[40] A program that is one of the following:

(a) A state Medicaid program under Title XIX of the Act.

(b) A state children's health insurance program (CHIP) under Title XXI of the Act.

(c) A program that makes available coverage in QHPs with financial assistance.

Health benefits. Any health-related program or benefit, administered or regulated by the state, including, but not limited to, QHPs, APTC, premium reductions, federal or state CSR, and Medicaid.

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[37] 26 CFR § 1.36B-1(h); 42 CFR § 435.4; 45 CFR § 155.410. The Treasury regulations uses the term “FPL” to describe this indicator: “FPL. The FPL means the most recently published poverty guidelines (updated periodically in the Federal Register by the Secretary of Health and Human Services under the authority of 42 USC § 9902(2)) as of the first day of the regular enrollment period for coverage by a QHP offered through an Exchange for a calendar year. Thus, the FPL for computing the premium tax credit for a benefit year is the FPL in effect on the first day of the initial or annual open enrollment period preceding that benefit year. See 45 CFR 155.410.” 26 CFR § 1.36B-1(h). For the sake of consistency, AHS has adopted HHS’s term for this concept, and uses it throughout this rule.

[38] 45 CFR § 155.20; 45 CFR § 147.140.

[39] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 45 CFR § 146.145(a).

[40] This term includes the programs referred to as “insurance affordability programs” in federal regulations. See, 42 CFR § 435.4; 45 CFR § 155.300.

Health insurance coverage.[41] Benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or HMO contract offered by a health insurance issuer. Health insurance coverage includes group health insurance coverage and individual health insurance coverage.

Health insurance issuer or issuer.[42] An insurance company, nonprofit hospital and medical service corporation, insurance service, or insurance organization (including an HMO) that is required to be licensed to engage in the business of insurance in a state and that is subject to state law that regulates insurance (within the meaning of section 514(b)(2) of ERISA).

Health plan.[43] This term has the meaning given in § 1301(b)(1) of the ACA. That section incorporates the definition found in § 2791(a) of the Public Health Service Act.

Human Services Board. AHS's fair hearings entity for eligibility issues. See, § 80.01.

Indian.[44] A person who is a member of an Indian tribe.

Indian tribe.[45] Any Indian tribe, band, nation or other organized group, or community, including pueblos, rancherias, colonies and any Alaska Native Village, or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

Individual. An applicant or enrollee for health benefits.

Institution.[46] An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more individuals unrelated to the proprietor.

Institutionalized individual. A person requesting Medicaid coverage of long-term care services and supports, whether the care is received in a home and community-based setting or in an institution licensed by AHS.

Institutionalized spouse (IS). For purposes of Medicaid, an institutionalized individual whose spouse qualifies as a community spouse.

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[41] 45 CFR § 155.20; 45 CFR § 144.103.

[42] 45 CFR §§ 155.20 and 156.20; 45 CFR § 144.103; 18 VSA § 9402(8).

[43] 45 CFR § 155.20.

[44] 25 CFR § 900.6.

[45] 25 CFR § 900.6.

[46] 42 CFR § 435.1010. This is the definition referred to in 42 CFR § 435.403(b) and 45 CFR § 155.305(a)(3). "Assisted living" is considered a community setting and not a medical institution or nursing facility because assisted living does not include 24-hour care, has privacy, a lockable door, and is a homelike setting. Former PP&D to Former Medicaid Rule 4201.

Interpreter. A person who orally translates for an individual who has limited English proficiency or an impairment. See, § 4.02(j).

Lawfully present. See, § 17.01(g).

Level of coverage.[47] One of four standardized actuarial values for plan coverage as defined by § 1302(d)(1) of the ACA: bronze, silver, gold or platinum.

Limited English proficiency. An ineffective ability to communicate in the English language for individuals who do not speak English as their primary language and may be entitled to language assistance with respect to a particular type of service, benefit or encounter.

Long-term care. Highest-need and high-need care, as determined by AHS, received by an individual living in a nursing facility, rehabilitation center, intermediate-care facility for the developmentally disabled (ICF-DD), and other medical facility for at least 30 consecutive days. It also includes care received by an individual in a home and community-based setting as specified in relevant waiver authorizations and any related program regulations.

For more information on Vermont's waiver governing terms and conditions, see: http://dvha.vermont.gov/administration.

Long-term care services and supports.[48] A range of medical, personal, and social services that can help an individual with functional limitations live their life more independently. Supports range from daily living (e.g. grocery shopping and food preparation) to 24-hour medical care provided in nursing facilities. Examples of long-term care services and supports include nursing facility services; a level of care in any institution equivalent to nursing facility services; home and community-based services to qualifying individuals as specified in relevant waiver authorizations or in any related program regulations, to include:

(a) Home-based and enhanced residential care services for the aged and disabled (known as "Choices for Care");

(b) Brain injury services;

(c) Home and community-based waiver services for the developmentally disabled (DS); and

(d) Children's mental health services.

For more information on Vermont's waiver governing terms and conditions, see: http://dvha.vermont.gov/administration. See, also, DVHA's Medicaid Covered Services Rule 7601.

Low-income Subsidy application data (LIS leads data). See, § 58.01(g).

MAGI-based income.[49] See, § 28.03.

[47] 45 CFR § 156.20; § 1302(d)(2) of the ACA.

[48] 42 CFR § 435.603(j)(4).

[49] 42 CFR §§ 435.4 and 435.603(e).

Medicaid for Children and Adults (MCA). The health-benefits program available to a member of a Medicaid coverage group for parents and other caretaker relatives, children, pregnant women, or adults under 65 years of age.

Medicaid for the Aged, Blind, and Disabled (MABD). The health-benefits program available to a member of a Medicaid coverage group for people who are aged, blind, or disabled. MABD is based on the requirements for two financial assistance programs federally administered by the Social Security Administration (SSA): the supplemental security income program (SSI) and aid to the aged, blind, and disabled program (AABD).

Medicaid group. Individuals who are considered in the financial-eligibility determination for MABD. The countable income and resources of the financial responsibility group are compared against the income and resource standards applicable to the Medicaid group's size. See § 29.04 for rules on the formation of the Medicaid group.

Medicaid services.[50] Medical benefits funded through Medicaid as specified in related program rules and waiver authorizations.

Medical incapacity. See, § 64.09.

Medical institution.[51] An institution that:

(a) Is organized to provide medical care, including nursing and convalescent care;

(b) Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients on a continuing basis and in accordance with accepted standards;

(c) Is authorized under state law to provide medical care; and

(d) Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

Medically needy.[52] Families; children; individuals who are aged, blind, or disabled; and pregnant women who are not categorically needy but who may be eligible for Medicaid because their income and, for individuals who are aged, blind or disabled, their resources are within limits set by the state under its Medicaid plan (including persons whose income and, if applicable, resources fall within these limits after their incurred expenses for medical or remedial care are deducted).

Medicare savings programs. See, § 8.07.

[50] *See,* Health Care Administrative Rules (HCAR) and Global Commitment to Health Section 1115 Waiver.

[51] 42 CFR § 435.1010.

[52] 42 CFR § 435.4.

Minimum essential coverage (MEC).[53] Health coverage under government-sponsored programs, employer-sponsored plans that meet specific criteria, grandfathered health plans, individual health plans, and certain other health-benefits coverage. See, § 23.00.

Minimum value.[54] When used to describe coverage in an eligible employer-sponsored plan, minimum value means that 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.

Modified adjusted gross income (MAGI). See, § 28.00.

Navigator.[55] An entity or individual selected by AHS and awarded a grant to provide assistance to individuals and employers with enrollment in Medicaid programs and qualified health plans, and to engage in the activities and meet the standards described in § 5.03.

Non-applicant.[56] A person who is not seeking an eligibility determination for himself or herself and is included in an applicant's or enrollee's household to determine eligibility for such applicant or enrollee.

Nonpayment. Failure to pay any or all of a premium due.

OASDI.[57] Old age, survivors, and disability insurance under Title II of the Act.

Optional state supplement.[58] A cash payment made by a state, under § 1616 of the Act, to an aged, blind, or disabled individual. *See*, AABD.

Patient share. See, § 24.00.

Personal needs allowance. See, § 24.04(c).

Physician's certificate. See, § 64.09.

Plan year.[59] A consecutive 12-month period during which a health plan provides coverage. For plan years beginning on January 1, 2015, a plan year must be a calendar year.

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[53] 42 CFR § 435.4; 45 CFR § 155.20.

[54] 45 CFR § 155.300; 45 CFR § 156.145; 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

[55] 45 CFR § 155.20; 33 VSA § 1807.

[56] 42 CFR § 435.4.

[57] 42 CFR § 435.4.

[58] 42 CFR § 435.4.

[59] 45 CFR §§ 155.20 and 156.20.

Plain language.[60] Language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well-organized, and follows other best practices of plain language writing.

Pregnant woman.[61] A woman during pregnancy and the post partum period, which begins on the date the pregnancy ends and extends 12 months, and then ends on the last day of the month in which the 12-month period ends.

Premium

(a) In general. A monthly charge that must be paid by an individual in order to receive health benefits.

(b) Initial premium. The premium for the first month of coverage.

(c) Ongoing premium. The premium for successive months of coverage, which are billed and due on a monthly basis.

Premium due date. The day on which a health-benefits premium is due.

Premium Reduction. State subsidy paid directly to the QHP issuer to reduce monthly premiums for an eligible individual enrolled in a QHP through VHC.

Private facility. Any home privately owned and operated, or any home or institution supported by private or charitable funds, over which neither the state nor any of its subdivisions has supervision or control even though individuals may be boarded or cared for therein at public expense. Vermont private institutions include boarding homes, fraternal homes, religious homes, community care homes, residential care facilities, medical facilities (i.e. general hospitals) and nursing facilities licensed by the State of Vermont.

Protected Income Level (PIL). The income standard for the medically-needy Medicaid coverage groups.

Public Institution. Any institution meeting all of the following conditions:

(a) The institution is owned, maintained, or operated in whole or in part by public funds;

(b) Control is exercised, in whole or in part, by any public agency or an official or employee of that agency; and

(c) The institution furnishes shelter and care and can be termed a public institution by reason of its origin, charter, ownership, maintenance or supervision.

Qualified Health Plan (QHP). A health plan certified by Vermont's Department of Financial Regulation (DFR) and offered by Vermont Health Connect.[62]

[60] 45 CFR § 155.20. Incorporates meaning of this term given in § 1311(e)(3)(B) of the ACA.

[61] 42 CFR § 435.4.

[62] 45 CFR §§ 155.20 and 156.20. 26 CFR § 1.36B-1(c) defines the term as follows: "QHP. The term QHP has the same meaning as in section 1301(a) of the ACA (42 USC § 18021(a)) but does not include a catastrophic plan described in

QHP issuer.[63] A health insurance issuer that offers a QHP in accordance with a certification from DFR.

Qualified individual.[64] For purposes of QHP, an individual who has been determined eligible by AHS to enroll in a QHP.

Qualifying coverage in an employer-sponsored plan.[65] Coverage in an eligible employer-sponsored plan that meets the affordability and minimum-value standards specified in 26 CFR § 1.36B-2(c)(3), and described in §§ 23.02 (affordable) and 23.03 (minimum value).

Quality control (QC). A system of continuing review to measure the accuracy of eligibility decisions. Also, the name of the AHS unit that is responsible for administering quality-control functions.

Reasonable compatibility. See, § 57.00(a).

Reenroll. To restore coverage after closure.

Reinstate. To restore eligibility after cancellation or closure.

Renew. For purposes of eligibility for health benefits, to redetermine eligibility at a specified periodic interval (*e.g.*, annual renewal of eligibility).

Secure electronic interface.[66] An interface that allows for the exchange of data between information technology systems and adheres to the requirements in subpart C of 42 CFR part 433.

Self-only coverage.[67] Health insurance that covers one individual and provides coverage for essential health benefits.

Special enrollment period (SEP).[68] A period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP outside of AOEPs. See, § 71.03.

Spouse. A husband, a wife or a party to a civil union according to the laws of the State of Vermont, except, for purposes of APTC/CSR, a husband or a wife if married within the meaning of 26 CFR § 1.7703-1. IRS's regulations

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section 1302(e) of the ACA (42 USC § 18022(e)."

[63] 45 CFR §§ 155.20 and 156.20.

[64] 45 CFR §§ 155.20 and 156.20.

[65] 45 CFR § 155.300.

[66] 42 CFR § 435.4.

[67] 26 CFR § 1.36B-1(l).

[68] 45 CFR § 155.20.

do not recognize parties to civil unions as “spouses.” Parties to civil unions are not permitted to file joint federal tax returns, but may qualify for APTC/CSR by filing separate tax returns.

SSI. Supplemental security income program under Title XVI of the Act.

Substantial gainful activity

(a) Work activity that is both substantial and gainful, defined as follows:

(1) Substantial work activity involves doing significant physical or mental activities. Work may be substantial even if it is done on a part-time basis or if individuals do less, get paid less or have less responsibility than when they worked before.

(2) Gainful work activity is the kind of work done for pay or profit whether or not a profit is realized.

(b) Individuals who are working with disabilities shall be exempt from the substantial gainful activity (SGA) step of the sequential evaluation of the disability determination if they otherwise meet the requirements set forth in § 8.05 for the categorically needy working disabled.

Tax filer.[69] For purposes of eligibility for a QHP with financial assistance, an individual who indicates that they expect:

(a) To file an income tax return for the benefit year;

(b) If married (within the meaning of 26 CFR § 1.7703-1), to file a joint tax return for the benefit year with their spouse (who, together with the individual, is considered the tax filer) unless the tax filer meets the exceptions criteria defined in § 12.03(b) (victim of domestic abuse or spousal abandonment);

(c) That no other taxpayer will be able to claim them as a tax dependent for the benefit year; and

(d) To claim a personal exemption deduction under § 151 of the Code on their tax return for one or more applicants, who may or may not include the individual or their spouse.

Tax dependent

(a) For purposes of eligibility for MAGI-based Medicaid, see, § 28.03(a).

(b) For purposes of eligibility for a QHP with financial assistance, see, § 28.05(a).

4.00 General program rules (01/01/2024, GCR 23-082)

4.01 Receiving health benefits from another state (01/15/2017, GCR 16-094)

An individual who is receiving health benefits from another state is not eligible for health benefits in Vermont.

4.02 Rights of individuals with respect to application for and receipt of health benefits through

[69] 45 CFR § 155.300.

AHS (01/01/2024, GCR 23-082)

(a) Notice of rights and responsibilities. Policies are administered in accordance with federal and state law. Individuals will be informed of their rights and responsibilities with respect to application for and receipt of health benefits.

(b) Right to nondiscrimination and equal treatment.[70] AHS does not unlawfully discriminate on the basis of race, color, religion, national origin, disability, age, sex, gender identity, or sexual orientation in the administration of its health-benefits programs or activities.

(c) Right to confidentiality. The confidentiality of information obtained during the eligibility process is protected in accordance with federal and state laws and regulations. The use and disclosure of information concerning applicants, enrollees, and legally-liable third parties is restricted to purposes directly connected with the administration of health-benefits programs, with enrollment in a QHP or as otherwise required by law.

(d) Right to timely provision of benefits. Eligible individuals have the right to the timely provision of benefits, as defined in § 61.00.

(e) Right to information. Individuals who inquire have the right to receive information about health benefits, coverage-type requirements, and their rights and responsibilities as enrollees of health-benefits programs or as enrollees in QHPs.

(f) Right to apply. Any person, individually or through an authorized representative or legal representative has the right, and will be afforded the opportunity without delay, to apply for benefits.

(g) Right to be assisted by others

(1) The individual has the right to be represented by a legal representative.

(2) The individual has the right to be accompanied and represented by an authorized representative during the eligibility or appeal processes.

(3) Upon request by the individual, copies of all eligibility notices and all documents related to the eligibility or appeal process will be provided to the individual's authorized or legal representative.

(4) An authorized representative may file an application for health benefits or an appeal on behalf of a deceased person.

(h) Right to inspect the case file. An individual has the right to inspect information in their case file and contest the accuracy of the information.

(i) Right to appeal. An individual has the right to appeal, as provided in § 68.00.

(j) Right to interpreter services. Individuals will be informed of the availability of interpreter services. Unless the

[70] See, 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502. See, also, All Programs Rule 2000(C).

individual chooses to provide their own interpreter services, AHS will provide either telephonic or other interpreter services whenever:

(1) The individual who is seeking assistance has limited English proficiency or sensory impairment (for example, a seeing or hearing disability) and requests interpreter services; or

(2) AHS determines that such services are necessary.

4.03 Responsibilities of individuals with respect to application for and receipt of health benefits through AHS (01/01/2024, GCR 23-082)

(a) Responsibility to cooperate. An individual must cooperate in providing information necessary to establish and maintain their eligibility, and must comply with all rules and regulations, including recovery and obtaining or maintaining available health insurance.

(b) Responsibility to report changes

(1) An individual must report changes that may affect eligibility. Such changes include, but are not limited to, income, the availability of health insurance, and third-party liability.

(2) A Medicaid enrollee must report such changes within 10 days of learning of the change.

(3) Except as specified in paragraphs (b)(4) and (5) of this subsection, a QHP enrollee must report such changes within 30 days of such change.

(4) A QHP enrollee who did not request an eligibility determination for APTC or CSR, and is not receiving APTC or CSR, need not report changes that affect eligibility for health-benefits programs.

(5) An individual, or an application filer on behalf of the individual, will be allowed to report changes via the channels available for the submission of an application, as described in § 52.02.

(c) Cooperation with quality control. An individual enrolled in a health-benefits program must cooperate with any quality-control (QC) review of their case. (§ 4.05)

4.04 Case records (01/01/2024, GCR 23-082)

(a) Contents. Case records include the following information:

(1) Applications for benefits;

(2) Factual data that supports eligibility findings, including, but not limited to:

(i) Documentation of verification of information submitted and any supplementary investigation of eligibility factors;

(ii) Budgetary computations;

(iii) Eligibility decisions; and

(iv) Payment authorizations.

(3) Copies of all correspondence with and concerning individuals, including, but not limited to, notices of case decisions.

(b) Use of case information. Case information may contribute in statistical or other general terms to material needed for planning, research, and overall administration of human-services programs. Individual case information shall, however, be held in accordance with the confidentiality requirements set forth in § 4.08.

(c) Retention. Case records are retained as required by federal and state requirements for audit and/or review.

4.05 Quality-control review (01/01/2024, GCR 23-082)

(a) AHS's Quality Control (QC) Unit periodically conducts independent reviews of eligibility factors in a sampling of cases. These reviews help to ensure that program rules are clear and consistently applied and that individuals understand program requirements and give correct information in support of their applications for benefits.

(b) A random sample of active Medicaid enrollees is chosen each month for a full field review of their eligibility. Each eligibility factor must be verified with the enrollee and with collateral sources.

(c) A similar sample of negative actions (e.g., denials, closures, benefit decreases) is also chosen each month. These reviews do not usually require a contact with the individual, although the reviewer may sometimes need to check facts with the individual.

(d) When a case is selected for review, the individual must cooperate with the QC representative. Cooperation includes, but is not limited to, participation in a personal interview and the furnishing of requested information. If the individual does not cooperate, eligibility for the individual's household may be closed and the individual members may be disenrolled.

(e) When there is a discrepancy between the eligibility facts, as discovered during a QC review, and those contained within the case record, AHS will schedule an eligibility review and take action to correct errors or review the effect of the changes.

4.06 Fraud (01/15/2017, GCR 16-094)

(a) Fraud. A person commits fraud in Vermont if he or she:

(1) "[K]nowingly fails, by false statement, misrepresentation, impersonation, or other fraudulent means, to disclose a material fact used in making a determination as to the qualifications of that person to receive aid or benefits under a state or federally funded assistance program, or who knowingly fails to disclose a change in circumstances in order to obtain or continue to receive under a program aid or benefits to which he or she is not entitled or in an amount larger than that to which he or she is entitled, or who knowingly aids and abets another person in the commission of any such act . . . ;"[71] or

[71] 33 VSA § 141(a).

(2) "[K]nowingly uses, transfers, acquires, traffics, alters, forges, or possesses, or who knowingly attempts to use, transfer, acquire, traffic, alter, forge, or possess, or who knowingly aids and abets another person in the use, transfer, acquisition, traffic, alteration, forgery, or possession of a . . . certificate of eligibility for medical services, or Medicaid identification card in a manner not authorized by law . . . ."[72]

(b) Legal consequences. An individual who commits fraud may be prosecuted under Vermont law. If convicted, the individual may be fined or imprisoned or both. Action may also be taken to recover the value of benefits paid in error due to fraud.

(c) AHS's responsibilities. An individual may report suspected fraud to AHS. When AHS suspects that fraud may have been committed, it will investigate the case. If appropriate, the case will be referred to the State's Attorney or Attorney General for a decision on whether or not to prosecute.

(d) Suspected fraud. The following criteria will be used to evaluate cases of suspected fraud to determine whether they should be referred to a law enforcement agency:

(1) Does the act committed appear to be a deliberately fraudulent one?

(2) Was the omission or incorrect representation an error or result of the individual's misunderstanding of eligibility requirements or the responsibility to provide information?

(3) Did the act result from AHS omission, neglect, or error in securing or recording information?

(4) Did the individual receive prior warning from a state employee that the same or similar conduct was improper?

(e) Examples

(1) The following are examples of instances in which fraud might be suspected and referral considered:

(i) The individual accepts and continues paid employment without reporting such employment after having been clearly informed of the necessity of such notification.

(ii) The individual fails to acknowledge or report income from pensions, Social Security, or relatives when it is reasonably clear that there was a willful attempt to conceal such income.

(iii) The individual disposes of property (either real or personal) and attempts to conceal such disposal.

(iv) The individual misrepresents a material fact, such as residency status or dependent relationship or status, in order to receive benefits to which they would not otherwise be eligible.

(2) These examples are intended as a guideline; each case will be evaluated individually.

(f) Methods of investigation. Any investigation of a case of suspected fraud is pursued with the same regard for

[72] 33 VSA § 141(b).

confidentiality and protection of the legal and other rights of the individual as with a determination of eligibility.

(g) Review and documentation of investigation. Procedures will be established for review and documentation of a fraud investigation.

(h) Referral to Law Enforcement Agencies. The final decision regarding referral to a law enforcement agency shall be the responsibility of the appropriate department's commissioner.

4.07 [Reserved] (01/15/2017, GCR 16-094)

4.08 Privacy and security of personally identifiable information[73] (01/15/2019, GCR 18-060)

(a) When personally-identifiable information is collected or created for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for health-benefits programs, or determining eligibility for exemptions from the individual responsibility provisions in § 5000A of the Code, such information will be used or disclosed only to the extent such information is necessary to administer health care program functions in accordance with federal and state laws.

(b) Requirements of AHS. AHS must establish and implement privacy and security standards that are consistent with the following principles.

(1)

(i) *Individual access*. Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction*. Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency*. There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information;

(iv) *Individual choice*. Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

(v) *Collection, use, and disclosure limitations*. Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity*. Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for

[73] See generally, Social Security Act §§ 1137 and 1902(a)(7); 26 USC §§ 6103; § 1413(c)(1) and (c)(2) of the ACA; 42 CFR Part 431, Subpart F; 45 CFR § 155.260; 45 CFR § 155.280.

the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards*. Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability and to prevent unauthorized or inappropriate access, use, or disclosure; and

(viii) *Accountability*. These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(2) Safeguards. For the purposes of implementing the principle described in paragraph (a)(1)(vii) of this subsection, AHS must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this subsection) to ensure:

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by AHS;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by § 6103(b)(2) of the Code, is kept confidential under § 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules.

(3) Monitoring. AHS must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(4) Secure interfaces. AHS must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

4.09 Use of standards and protocols for electronic transactions (01/15/2017, GCR 16-094)

(a) HIPAA administrative simplification.[74] To the extent that electronic transactions are performed with a covered entity, standards, implementation specifications, operating rules, and code sets adopted by the Secretary of HHS in 45 CFR parts 160 and 162 will be used.

[74] 45 CFR § 155.270(a).

(b) HIT enrollment standards and protocols.[75] Interoperable and secure standards and protocols developed by the Secretary of HHS in accordance with § 3021 of the PHS Act will be incorporated. Such standards and protocols will be incorporated within VHC information technology systems.

5.00 Eligibility and enrollment assistance (01/01/2027, GCR 26-051)

5.01 Assistance offered through AHS (01/01/2026, GCR 25-050)

(a) In general.[76] AHS will provide assistance to any individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient. Eligibility and enrollment assistance that meets the accessibility standards in paragraph (c) of this subsection is provided, and referrals are made to assistance programs in the state when available and appropriate. These functions include assistance provided directly to any individual seeking help with the application or renewal process.

(b) Assistance tools

(1) Call center.[77] A toll-free call center is provided to address the needs of individuals requesting assistance and meets the accessibility requirements outlined in paragraph (c) of this subsection. The call center will provide individuals with access to a live call center representative during the call center's published hours of operation who may assist the individuals with filing their applications, including providing information to them on their eligibility for APTC and CSR, facilitating a comparison of QHPs, and helping them complete their applications for submission to AHS.

(2) Internet website.[78] An up-to-date internet website that meets the requirements outlined in paragraph (c) of this subsection is maintained. The website:

(i) Supports applicant and enrollee activities, including accessing information on the health-benefit programs available in the state, applying for and renewing coverage and providing assistance to individuals seeking help with the application or renewal process;

(ii) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools,

[75] 45 CFR § 155.270(b).

[76] 42 CFR § 435.908; 45 CFR § 155.205(d). Note: While the consumer-assistance responsibilities of Medicaid agencies and Exchanges may be distinct, "[s]ome aspects of [the Medicaid agency's] applicant and beneficiary assistance may be integrated with the consumer assistance tools and programs of the Exchange." See, CMS "Summary of Proposed Provisions and Analysis of and Responses to Public Comments," 77 Fed. Reg. 17144, 17166 (Mar. 23, 2011). Vermont has opted to operate one health-benefits assistance call center, serving the needs of all applicants and beneficiaries of health benefits.

[77] 42 CFR § 435.908; 45 CFR § 155.205(a).

[78] Social Security Act § 1943 (42 USC § 1396w-3); 42 CFR § 435.1200(f); 45 CFR § 155.205(b).

including at a minimum:

(A) Premium and cost-sharing information;

(B) The summary of benefits and coverage established under § 2715 of the PHS Act;

(C) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by § 1302(d) of the ACA, or a catastrophic plan as defined by § 1302(e) of the ACA;

(D) The results of the enrollee satisfaction survey, as described in § 1311(c)(4) of the ACA;

(E) Beginning 2015, quality ratings assigned in accordance with § 1311(c)(3) of the ACA;

(F) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;

(G) Transparency of coverage measures reported to VHC during certification; and

(H) The provider directory made available to VHC.

(iii) Publishes the following financial information:

(A) The average costs of licensing required by VHC;

(B) Any regulatory fees required by VHC;

(C) Any payments required by VHC in addition to fees under paragraphs (b)(2)(iii)(A) and (B) of this subsection;

(D) Administrative costs of VHC; and

(E) Monies lost to waste, fraud, and abuse.

(iv) Provides individuals with information about Navigators as described in § 5.03 and other consumer assistance services, including the toll-free telephone number of the call center required in paragraph (b)(1) of this subsection.

(v) Allows for an individual to submit a single, streamlined eligibility application to AHS in accordance with § 52.02 and for AHS to make all determinations of eligibility for enrollment in a QHP and insurance affordability programs in accordance with § 58.00, through the operation of a centralized eligibility and enrollment platform.

(vi) Allows a qualified individual to select a QHP in accordance with § 71.00, and allows AHS to maintain records of all QHP enrollments through the operation of a centralized eligibility and enrollment platform.

(vii) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any APTC, premium reductions and any federal or state CSR.

(c) Accessibility[79]

(1) Information is provided in plain language and in a manner that is accessible and timely.

(2) Individuals living with disabilities will be provided with, among other things, accessible websites and auxiliary aids and services at no cost to the individual, in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act.

(3) For individuals with limited English proficiency, language services will be provided at no cost to the individual, including:

(i) Oral interpretation, including telephonic interpreter services;

(ii) Written translations;

(iii) Taglines in non-English languages indicating the availability of language services; and

(iv) Website translations.

(4) Individuals will be informed of the availability of the services described in this paragraph and how they may access such services.

(d) Availability of program information[80]

(1) The following information is furnished in electronic and paper formats, and orally as appropriate, to all individuals who request it:

(i) The eligibility requirements;

(ii) Available health benefits and services; and

(iii) The rights and responsibilities of individuals.

(2) Bulletins or pamphlets that explain the rules governing eligibility and appeals in simple and understandable terms will be published in quantity and made available.

(3) Such information is provided in a manner that meets the standards in paragraph (c) of this subsection.

(e) Outreach and education.[81] Outreach and education activities that meet the standards in paragraph (c) of this subsection to educate consumers about VHC and Vermont's health-benefits programs to encourage participation will be conducted.

[79] 42 CFR § 435.905(b); 45 CFR § 155.205(c).

[80] 42 CFR § 435.905; 45 CFR § 155.205.

[81] Social Security Act § 1943 (42 USC § 1396w-3); 45 CFR § 155.205(e).

(f) Americans with Disabilities Act (ADA).[82] As required by the Americans with Disabilities Act, reasonable accommodations and modifications will be made to policies, practices, or procedures when necessary, as determined by the appropriate commissioners or their designees, to provide equal access to programs, services and activities, or when necessary to avoid discrimination on the basis of disability. An individual may appeal the commissioner's determination regarding necessity to the appropriate fair hearings entity or appeals entity in accordance with departmental regulations governing appeals and fair hearings.

(g) Non-discrimination.[83] AHS assistance programs and activities will:

(1) Comply with applicable non-discrimination statutes; and

(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

5.02 Authorized representatives[84] (01/01/2024, GCR 23-082)

(a) In general

(1) An individual may designate another person or organization to accompany, assist, and represent or to act responsibly on their behalf in assisting with the individual's application and renewal of eligibility and other ongoing communications with AHS. These include:

(i) Guardians and people with powers of attorney (§ 5.02(i)); and

(ii) Any other person of the individual's choice.

(2) AHS may permit an applicant or enrollee to authorize a representative to perform fewer than all of the activities described in paragraph (b)(1) of this subsection, provided that AHS tracks the specific permissions for each authorized representative.

(3) Except as provided in paragraph (h) of this subsection, and consistent with current state policy and practice, designation of an authorized representative must be in writing, including the individual's signature, or through another legally binding format subject to applicable authentication and data security standards.

(4) Designation will be permitted at the time of application and at other times.

(5) Legal documentation of authority to act on behalf of an individual under state law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of written authorization by the individual. In such cases AHS may recognize an individual as an authorized representative before the

[82] All Programs Rule 2030.

[83] 42 USC § 18116; 45 CFR §§ 92.2 and 155.120(c)(1); 9 VSA § 4502.

[84] 42 CFR §§ 435.908(b) and 435.923; 45 CFR § 155.227.

legal documentation is provided to AHS.

(6) When an individual dies before applying for retroactive Medicaid coverage, the administrator or executor of the individual's estate, a surviving relative or responsible person may act as the individual's representative.

(b) Scope of authority

(1) Representatives may be authorized to do any or all of the following:

(i) Assist the individual in completing and submitting any health-benefits application, verification, or other documentation with AHS;

(ii) Give and receive information regarding the individual's application or enrollment;

(iii) Sign an application on the individual's behalf;

(iv) Receive copies of the individual's notices and other communications. A person who receives authority to only receive copies of communications is referred to as an "alternate reporter";

(v) Request a fair hearing or file a grievance; and

(vi) Act on behalf of the individual in any other matters with AHS.

(2) The kinds of information that may be shared may include the following:

(i) Information or proofs needed to complete the application or redetermination of eligibility;

(ii) The status of the application including the program or programs the household members are enrolled in and the effective dates of enrollment;

(iii) The reason the individual or household is not eligible for a benefit, if the application is denied or benefits end; and

(iv) The effective date of redetermination and any outstanding information or verifications needed to complete a redetermination.

(c) Duration of authorization

(1) The power to act as an authorized representative is valid with AHS until:

(i) The individual modifies the authorization or notifies AHS, using one of the methods available for the submission of an application, as described in § 52.02(b)(2), that the representative is no longer authorized to act on their behalf;

(ii) The authorized representative informs AHS that they no longer are acting in such capacity; or

(iii) There is a change in the legal authority upon which the individual or organization's authority was based.

(2) Any notification described in (c)(1) of this subsection, except as stated in (c)(1)(i), must be in writing and should include the individual's or authorized representative's signature as appropriate.

(d) Duties of the authorized representative. The authorized representative:

(1) Is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in paragraph (b) of this subsection, to the same extent as the individual they represent; and

(2) Must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the individual provided.

(e) Condition of representation

(1) The authorized representative must agree to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by AHS.

(2) When an organization is designated as an authorized representative, as a condition of serving, staff members or volunteers of that organization must sign an agreement that they will adhere to the regulations in § 4.08 (relating to confidentiality of information), federal regulations relating to the prohibition against reassignment of provider claims as appropriate for a health facility or an organization acting on the facility's behalf, as well as other relevant state and federal laws concerning conflicts of interest and confidentiality of information.

(f) Form of authorization. For purposes of this subsection, electronic, including telephonically recorded, signatures and handwritten signatures transmitted by facsimile or other electronic transmission will be accepted. Designations of authorized representatives will be accepted through all of the modalities described in § 52.02(b).

(g) Disclosures. The authorization form or the AHS call center representative (if the authorization is made over the telephone) shall advise that:

(1) The individual need not give permission to share information.

(2) If the individual decides not to give permission, that will not affect eligibility for, or enrollment in, benefits;

(3) If the individual does not give permission, the information will not be released unless the law otherwise allows it;

(4) AHS is not responsible for what an unrelated authorized representative does with the individual's information after it is shared pursuant to a valid authorization;

(5) The individual may change or stop this authorization at any time by notifying AHS by telephone or in writing. However, doing so will not affect previously shared information;

(6) If the individual does not change or stop the authorization, it will remain in effect as long as the individual (or household) continues to receive health-care benefits; and

(7) The individual will be provided with a copy of the authorization upon request.

(h) Minors and incapacitated adults.[85] If the individual is a minor or an incapacitated adult, no authorization is required; someone acting responsibly for the individual may assist in the application process or during a redetermination of eligibility. Such person may also sign the initial application on the applicant's behalf.

(i) Judicially-appointed legal guardian or representative.[86] Upon presentment of a valid document of appointment, a judicially-appointed legal guardian or representative may act on an individual's behalf.

5.03 Navigator program (01/01/2027, GCR 26-051)

(a) General requirements.[87] AHS conducts a Navigator program consistent with this subsection through which it awards grants to eligible entities to perform the functions of navigator organizations, and certifies individuals as Navigators. The functions of navigator organizations include providing assistance to individuals and employers with enrollment in Medicaid programs and qualified health plans.

(b) Standards.[88] AHS maintains and publicly disseminates:

(1) A set of standards, to be met by all entities and individuals to be awarded Navigator grants, designed to prevent, minimize, and mitigate any conflicts of interest, financial or otherwise, that may exist for an entity to be awarded a Navigator grant, and to ensure that all entities and individuals carrying out Navigator functions have appropriate integrity; and

(2) A set of training standards, to be met by all entities and individuals carrying out Navigator functions under the terms of a Navigator grant, to ensure expertise in:

(i) The needs of underserved and vulnerable populations;

(ii) Eligibility and enrollment rules and procedures;

(iii) Benefits rules and regulations governing all health-benefits programs and QHPs offered in the state;

(iv) The range of QHP options and health-benefits programs;

(v) The privacy and security standards applicable under § 4.08;

(vi) The process of filing eligibility appeals;

(vii) General concepts regarding exemptions from the requirement to maintain minimum essential

[85] 42 CFR § 435.907(a); 45 CFR § 155.20.

[86] All Programs Rule 2014.

[87] 45 CFR § 155.210(a); 33 VSA § 1807.

[88] 45 CFR §§ 155.205(d) and 155.210(b).

coverage and from the individual shared responsibility payment, including the application process for exemptions, and IRS resources and exemptions;

(viii) The premium tax credit reconciliation process and IRS resources on this process;

(ix) Basic concepts and rights related to health coverage and how to use it; and

(x) Providing referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice.

(c) Entities and individuals eligible to be a Navigator.[89] To receive a Navigator grant, an entity must:

(1) Be capable of carrying out at least those duties described in paragraph (f) of this subsection;

(2) Demonstrate to AHS that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

(3) Meet any licensing, certification or other standards prescribed by the state or AHS;

(4) Not have a conflict of interest during the term as Navigator; and

(5) Comply with the privacy and security standards applicable under § 4.08.

(d) Prohibition on Navigator conduct.[90] A Navigator must not:

(1) Be a health insurance issuer or issuer of stop loss insurance;

(2) Be a subsidiary of a health insurance issuer or issuer of stop loss insurance;

(3) Be an association that includes members of, or lobbies on behalf of, the insurance industry;

(4) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or a non-QHP;

(5) Charge any applicant or enrollee, or request or receive any form of remuneration from or on behalf of an individual applicant or enrollee, for application or other assistance related to Navigator duties;

(6) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph, the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third

[89] 45 CFR § 155.210(c).

[90] 45 CFR § 155.210(d).

party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive application assistance, such as, but not limited to, travel or postage expenses;

(7) Use AHS funds to purchase gifts or gift cards, or promotional items that market or promote the products or services of a third party, that would be provided to any applicant or potential enrollee;

(8) Solicit any individual for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling an individual to provide application or enrollment assistance without the individual initiating the contact, unless the individual has a pre-existing relationship with the individual Navigator or Navigator entity and other applicable state and federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling an individual; or

(9) Initiate any telephone call to an individual using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual Navigator or Navigator entity has a relationship with the individual and so long as other applicable state and federal laws are otherwise complied with.

(e) Conflict-of-interest standards.[91] In addition to prohibited conduct in (d) of this subsection, the following standards apply to Navigators:

(1) All Navigator entities must submit to VHC a written attestation that the Navigator, including the Navigator's staff, complies with (d)(1).

(2) All Navigator entities must submit to VHC a written plan to remain free of conflicts of interest during the term as a Navigator.

(3) All Navigator entities, including the Navigator's staff, must provide information to consumers about the full range of QHP options and health-benefits programs for which they are eligible.

(4) All Navigator entities, including the Navigator's staff, must disclose to VHC and, in plain language, to each consumer who receives application assistance from the Navigator:

(i) Any lines of insurance business, not covered by the restrictions on participation and prohibitions on conduct in (d) of this subsection, which the Navigator intends to sell while carrying out the consumer assistance functions;

(ii) Any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

(iii) For Navigator staff, any existing employment relationships, or any former employment relationships within the last 5 years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or

[91] 45 CFR § 155.215(a).

issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance.

(f) Duties of a Navigator.[92] An entity that serves as a Navigator must carry out at least the following duties:

(1) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about VHC;

(2) Conduct public education activities to raise awareness of the availability of qualified health benefit plans;

(3) Distribute information to health care professionals, community organizations, and others to facilitate the enrollment of individuals who are eligible for Medicaid, Dr. Dynasaur, VPharm, other public health-benefits programs, or QHP;

(4) Provide information and services in a fair, accurate and impartial manner, which includes providing information that assists individuals with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping individuals make informed decisions during the health coverage selection process. Such information must acknowledge other health programs;

(5) Distribute fair and impartial information concerning enrollment in QHPs and concerning the availability of premium tax credits, premium reductions, and cost-sharing reductions;

(6) Facilitate selection of a QHP or public health-benefits program such as Medicaid, Dr. Dynasaur, or VPharm;

(7) Provide referrals to any applicable office of health insurance consumer assistance, health insurance ombudsman, or any other appropriate state agency or agencies, for any individual with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage;

(8) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by VHC, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act;

(9) Ensure that individuals:

(i) Are informed, prior to receiving assistance, of the functions and responsibilities of Navigators, including that Navigators are not acting as tax advisers or attorneys when providing assistance as Navigators and cannot provide tax or legal advice within their capacity as Navigators;

(ii) Provide authorization in a form and manner as determined by AHS prior to a Navigator's obtaining access to an individual's personally identifiable information, and that the Navigator maintains a record of the authorization provided in a form and manner as determined by AHS. AHS will establish

[92] 45 CFR § 155.210(e); 33 VSA § 1807.

a reasonable retention period for maintaining these records; and

(iii) May revoke at any time the authorization provided to a Navigator.

(10) Maintain a physical presence in the service area, so that face-to-face assistance can be provided to applicants and enrollees;

(11) Provide targeted assistance to serve underserved or vulnerable populations, as identified by AHS;

(12) Provide information and assistance with the following topics:

(i) Understanding the process of filing eligibility appeals;

(ii) Understanding the availability of exemptions from the requirement to maintain minimum essential coverage that are claimed through the federal government and how to claim them, and understanding the availability of resources on this topic;

(iii) The premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;

(iv) Understanding basic concepts and rights related to health coverage and how to use it; and

(v) Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice.

(13) Provide information and services to any member of the public seeking eligibility and enrollment assistance from a Navigator.

(g) Funding for Navigator grants. Funding for navigator grants may not be from Federal funds received by the state to establish VHC.

5.04 Brokers (01/01/2027, GCR 26-051)

(a) General rule.[93] A broker may:

(1) Facilitate enrollment of an individual, employer, or employee in any QHP as soon as the QHP is offered;

(2) Subject to paragraphs (b) and (c) of this subsection, assist an individual in applying for a QHP with financial assistance; and

(3) Subject to paragraphs (b) and (c) of this subsection assist an employee or an employer in enrolling in any QHP.

(b) Agreement.[94] Prior to enrolling a qualified individual, employee, or employer in a QHP through VHC, or

[93] 45 CFR § 155.220(a); 33 VSA § 1805(17).

[94] 45 CFR § 155.220(d); 33 VSA § 1805(17).

assisting an individual in applying for a QHP with financial assistance, a broker must have an executed agreement with AHS, and must comply with the terms of that agreement, which includes at least the following requirements:

(1) Registering with AHS in advance of assisting a qualified individual, employee or employer, enrolling in QHPs through VHC;

(2) Receiving training in the range of QHP options and health-benefit programs;

(3) Complying with AHS's privacy and security standards adopted consistent with § 4.08;

(4) Maintaining a physical presence in the service area, so that face-to-face assistance can be provided to applicants and enrollees; and

(5) Providing assistance in a manner consistent with professional standards for licensed Vermont insurance producers.

(c) Payment mechanisms.[95] A broker who facilitates enrollment of an individual, employer, or employee in any QHP may charge a reasonable fee for assisting with the enrollment of qualified individuals and qualified employers in any QHP offered through VHC for which the individual or employer is eligible; and assisting a qualified individual in applying for financial assistance for a QHP purchased through VHC. A QHP issuer may not pay any part of a broker fee.[96]

(d) Web broker prohibition. Vermont does not permit a broker or any entity that is not a QHP issuer to develop and host a non-exchange website to assist consumers with direct enrollment in a QHP offered through VHC.[97]

5.05 Certified application counselors[98] (01/01/2027, GCR 26-051)

(a) In general. AHS certifies staff and volunteers of state-partner organizations to act as application counselors, authorized to provide assistance to individuals with the application process and during renewal of eligibility.

(b) Certification

(1) Application counselors are certified by AHS to provide assistance at application and renewal with respect to one, some, or all of the permitted assistance activities, and enter into certification agreements with AHS.

[95] 33 VSA § 1805(17).

[96] 8 VSA § 4022.

[97] 45 CFR § 155.20. See, also, 45 CFR §§ 155.220 and 155.221.

[98] 42 CFR § 435.908; 45 CFR § 155.225.

(2) To be certified, application counselors must:

(i) Be authorized and registered by AHS to provide assistance at application and renewal;

(ii) Be effectively trained in the eligibility and benefits rules and regulations governing enrollment in a QHP and all health-benefits programs operated in Vermont;

(iii) Have successfully completed the required training and received a passing score on the certification examination;

(iv) Disclose to AHS and potential applicants any relationships the certified application counselor or sponsoring agency has with QHPs or insurance affordability programs, or other potential conflicts of interest;

(v) Comply with AHS's privacy and security standards adopted consistent with § 4.08 and applicable authentication and data security standards;

(vi) Agree to act in the best interest of the applicants assisted;

(vii) Either directly or through an appropriate referral to the VHC call center, provide information in a manner that is accessible to individuals with disabilities, as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. § 12101 *et seq*. and § 504 of the Rehabilitation Act, as amended, 29 USC § 794; and

(viii) Be recertified on at least an annual basis after successfully completing recertification training as required by AHS.

(c) Withdrawal of certification. AHS will establish procedures to withdraw certification from individual application counselors, or from all application counselors associated with a particular organization, when it finds noncompliance with the terms and conditions of the application counselor agreement.

(d) Duties. Certified application counselors must carry out the following duties as a condition of their certification:

(1) Provide information to individuals and employees about the full range of QHP options and health-benefits programs for which they are eligible, which includes providing fair, impartial and accurate information that assists individuals with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping individuals make informed decisions during the health coverage selection process;

(2) Assist individuals and employees to apply for coverage in a QHP through VHC and for health-benefits programs;

(3) Help to facilitate enrollment of eligible individuals in QHPs and health-benefits programs; and

(4) Provide information and services to any member of the public seeking eligibility and enrollment assistance or refer them to another source of eligibility and enrollment assistance.

(e) Availability of information; authorization. AHS must establish procedures to ensure that:

(1) Individuals are informed, prior to receiving assistance, of the functions and responsibilities of certified application counselors, including that certified application counselors are not acting as tax advisers or attorneys when providing assistance as certified application counselors and cannot provide tax or legal advice within their capacity as certified application counselors;

(2) Individuals are able to provide authorization in a form and manner as determined by AHS prior to a certified application counselor obtaining access to personally identifiable information about the individual related to the individual's application for, or renewal of, health benefits, and that the organization or certified application counselor maintains a record of the authorization in a form and manner as determined by AHS. AHS will establish a reasonable retention period for maintaining these records;

(3) AHS does not disclose confidential individual information to an application counselor unless the individual has authorized the application counselor to receive such information; and

(4) Individuals may revoke at any time the authorization provided the certified application counselor.

(f) No charge for services. Application counselors may not:

(1) Impose any charge on individuals for application or other assistance related to VHC;

(2) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individual in a QHP or a non-QHP;

(3) Provide to an applicant or potential enrollee gifts of any value as inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph, the term gifts includes gift items, gift cards, cash cards, cash and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive application assistance, such as, but not limited to, travel or postage expenses;

(4) Solicit any individual for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling an individual to provide application or enrollment assistance without the individual initiating the contact, unless the individual has a pre-existing relationship with the individual certified application counselor or designated organization and other applicable state and federal laws are otherwise complied with. Outreach and education activities may be conducted by going door-to-door or through other unsolicited means of direct contact, including calling an individual; or

(5) Initiate any telephone call to an individual using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual certified application counselor or designated organization has a relationship with the individual and so long as other applicable state and federal laws are otherwise complied with.

(g) Non-discrimination and organizations receiving federal funds to provide services to defined populations.[99]

[99] 45 CFR § 155.120(c)(2).

Notwithstanding the non-discrimination provisions of § 5.01(g), an organization that receives federal funds to provide services to a defined population under the terms of federal legal authorities that participates in the certified application counselor program may limit its provision of certified application counselor services to the same defined population, but must comply with § 5.01(g) with respect to the provision of certified application counselor services to that defined population, If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the individual to other AHS-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with § 5.01(g).

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.)

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.

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.)

OFFICE OF THE SECRETARY OF STATE

VERMONT STATE ARCHIVES & RECORDS ADMINISTRATION (VSARA)

(802) 828-2863

TO:	Seven Days Legals (legals@sevendaysvt.com)	Tel: (802) 865-1020 x110.
	The Caledonian Record (adv@caledonian-record.com)	Tel: 748-8121 FAX: 748-1613
	Times Argus / Rutland Herald Classified Ads (classified.ads@rutlandherald.com)	Tel: 802-747-6121 ext 2238 FAX: 802-776-5600
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	The Addison Independent (legals@addisonindependent.com)	Tel: 388-4944 FAX: 388-3100 Attn: Display Advertising
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	The Chronicle (ads@bartonchronicle.com)	Tel: 525-3531 FAX: 525-3200
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	Newport Daily Express (jlafoe@newportvermontdailyexpress.com)	Tel: 334-6568 FAX: 334-6891 Attn: Jon Lafoe
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	St. Albans Messenger Legals (legals@samessenger.com; cfoley@orourkemediagroup.com)	Tel: 524-9771 ext. 117 FAX: 527-1948 Attn: Legals
	The Islander (islander@vermontislander.com)	Tel: 802-372-5600 FAX: 802-372-3025
	Vermont Lawyer (hunter.press.vermont@gmail.com)	Attn: Will Hunter
	VT Digger (legals@vtdigger.org)	Attn: Legals

FROM: APA Coordinator, VSARA **Date of Fax:** October 13, 2026

RE: The "Proposed State Rules " ad copy to run on **July 23, 2026**

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 proposed rule(s) you are interested in.

- Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1).
  Vermont Proposed Rule: **26P020**
- Health Benefits Eligibility and Enrollment Rule, Eligibility Standards (Part 2).
  Vermont Proposed Rule: **26P021**
- Health Benefits Eligibility and Enrollment Rule, Nonfinancial Eligibility Requirements (Part 3).
  Vermont Proposed Rule: **26P022**
- Health Benefits Eligibility and Enrollment Rule, Financial Methodologies (Part 5).
  Vermont Proposed Rule: **26P023**
- Health Benefits Eligibility and Enrollment Rule, Eligibility-and-Enrollment Procedures (Part 7).
  Vermont Proposed Rule: **26P024**

AGENCY: Agency of Human Services

CONCISE SUMMARY: These proposed rules amend parts 1-3, 5 and 7 of the 8-part Health Benefits Eligibility and Enrollment (HBEE) rules. Parts 1,2,3,5 and 7 were last amended effective January 1, 2026. Substantive revisions include: newly requiring certain adult Medicaid applicants and enrollees demonstrate compliance with work and community engagement rules as a factor of eligibility; reducing the retroactive Medicaid coverage period from three months to one month for Adult coverage group enrollees and two months for all other enrollees; restricting non-citizen eligibility for both Medicaid and Qualified Health Plan premium tax credits and adding a new category of "eligible non-citizen" to clarify which individuals remain eligible; adjusting the renewal period from 12 to 6 months for Medicaid enrollees in the Adult coverage group; shortening the annual open enrollment period from November 1st-January 15th to November 1st - December 15th. All of these substantive revisions are required by federal law.

FOR FURTHER INFORMATION, CONTACT: Emily Belanger, Agency of Human Services 280 State Drive, NOB 1 South, Waterbury, VT 05671-1010 Tel: 802-760-0118 Fax: 802-241-0450 E-mail: emily.m.belanger@vermont.gov URL: https://humanservices.vermont.gov/rules-policies/health-care-rules.

FOR COPIES: Jessica Ploesser, Agency of Human Services, 5 Pilgrim Park, 1st Floor Suite 2, Waterbury, VT 05671-1010 Tel: 802-241-0454 Fax: 802-241-0260 E-mail: jessica.ploesser@vermont.gov.

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(802) 828-2863

MEMORANDUM OFFICE OF THE SECRETARY OF STATE

Primary Contact: Emily Belanger, Agency of Human Services 280 State Drive, NOB 1 South, Waterbury, VT 05671-1010 Tel: 802-760-0118 Fax: 802-241-0450 E-mail: emily.m.belanger@vermont.gov

Secondary Contact: Jessica Ploesser, Agency of Human Services, 5 Pilgrim Park, 1st Floor Suite 2, Waterbury, VT 05671-1010 Tel: 802-241-0454 Fax: 802-241-0260 E-mail: jessica.ploesser@vermont.gov.

URL: https://humanservices.vermont.gov/rules-policies/health-care-rules

From: APA Coordinator, VSARA

RE: Health Benefits Eligibility and Enrollment Rule, General Provisions and Definitions (Part 1).

Date 10/13/2026

We received Proposed Rule on 07/10/2026
Final Proposed Rule on 10/09/2026
Adopted Rule on
We have assigned the following rule number(s):
Proposed Rule Number: 26P020
Adopted Rule Number:
(Final Proposals are not assigned a new number; they retain the Proposed Rule Number.)

The following problems were taken care of by phone/should be taken care of immediately:

We cannot accept this filing until the following problems are taken care of:

The ad for this proposed rule appeared/will appear in newspapers of record on 07/23/2026 & / / .

This rule takes effect on
Adoption Deadline: 03/10/2027

Please note: The agency has requested a combined notice for 26P020, 26P021, 26P022, 26P023, and 26P024.

If you have any questions, please call me at 828-2863. OR
E-Mail me at: sos.statutoryfilings@vermont.gov

cc: Megan Cannella