FINAL PROPOSED RULE # 26-P022

Final Proposed Filing - Coversheet

Instructions:

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

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

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

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

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

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

/s/ 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

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

2. PROPOSED NUMBER ASSIGNED BY THE SECRETARY OF STATE
   26P022

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=1eCIIA3r4n2nvslTbO

Date:

Time: AM

Street Address:

Zip Code:

URL for Virtual:

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.

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).

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, Nonfinancial Eligibility Requirements (Part 3)
2. ADOPTING AGENCY:
   Agency of Human Services (AHS)
3. TYPE OF FILING (*PLEASE CHOOSE THE TYPE OF FILING FROM THE DROPDOWN MENU BASED ON THE DEFINITIONS PROVIDED BELOW*):

   - **AMENDMENT -** Any change to an already existing rule, even if it is a complete rewrite of the rule, it is considered an amendment if the rule is replaced with other text.
   - **NEW RULE -** A rule that did not previously exist even under a different name.
   - **REPEAL** - The removal of a rule in its entirety, without replacing it with other text.

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

4. LAST ADOPTED (*PLEASE PROVIDE THE SOS LOG#, TITLE AND EFFECTIVE DATE OF THE LAST ADOPTION FOR THE EXISTING RULE)*:
   Part 1 - General Provisions and Definitions, SOS # 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.

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, Nonfinancial Eligibility Requirements (Part 3)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

3. CATEGORY OF AFFECTED PARTIES:

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

   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, Nonfinancial Eligibility Requirements (Part 3)

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

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

2. ADOPTING AGENCY:

   Agency of Human Services (AHS)

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

   AHS consulted with key stakeholders on the development of policies in this rulemaking. 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.

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.

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

Table of Contents

Part Three Nonfinancial eligibility requirements 1

15.00 Nonfinancial eligibility requirements, in general 1

16.00 Social Security number 1

16.01 Medicaid 1

16.02 QHP 2

17.00 Citizenship and immigration status 3

17.01 Definitions 3

17.02 General Rules 7

17.03 Medicaid eligibility of non-citizens including the applicability of the five-year bar 8

18.00 Assignment of rights and cooperation requirements for Medicaid 11

18.01 In general 11

18.02 Assignment of rights to payments 11

18.03 Cooperation in Obtaining Payments 11

18.04 Good cause for noncooperation 12

18.05 Enrollment in a health insurance plan 13

19.00 Incarceration and QHP eligibility 13

19.01 In general 13

19.02 Exception 13

20.00 Living arrangements for Medicaid eligibility purposes 13

20.01 In general 13

20.02 Correctional facility 14

20.03 Determination of residence in an institution 15

20.04 Homeless individuals 15

20.05 Financial responsibility and living arrangement 15

21.00 Residency 15
21.01 In general 15
21.02 Incapability of indicating intent 15
21.03 Who is a state resident 16
21.04 Placement by a state in an out-of-state institution 16
21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD) 16
21.06 An individual age 21 and over 17
21.07 An individual receiving Title IV-E payments 18
21.08 An individual under age 21 18
21.09 Specific prohibitions 19
21.10 Interstate agreements 19
21.11 Cases of disputed residency 19
21.12 Special rule for tax households with members in multiple Exchange service areas 19
21.13 Temporary absences from the state 20
21.14 Vermont residence as Medicaid payment requirement 20
22.00 [Reserved] 20
23.00 Minimum essential coverage 20
23.01 Minimum essential coverage 20
23.02 Affordable coverage for employer-sponsored MEC 26
23.03 Minimum value for employer-sponsored MEC 29
23.04 Enrollment in eligible employer-sponsored plan 29
23.05 Special eligibility rules 29
23.06 Eligibility determinations for MEC exemptions 30
~~Part Three Nonfinancial eligibility requirements ..... 1~~
~~15.00 Nonfinancial eligibility requirements, in general ..... 1~~
~~16.00 Social Security number ..... 1~~

16.01 Medicaid 1
16.02 QHP 2
17.00 Citizenship and immigration status 3
17.01 Definitions 3
17.02 General Rules 9
17.03 Medicaid eligibility of non-citizens including the applicability of the five-year bar 10
18.00 Assignment of rights and cooperation requirements for Medicaid 12
18.01 In general 13
18.02 Assignment of rights to payments 13
18.03 Cooperation in Obtaining Payments 13
18.04 Good cause for noncooperation 13
18.05 Enrollment in a health insurance plan 14
19.00 Incarceration and QHP eligibility 14
19.01 In general 15
19.02 Exception 15
20.00 Living arrangements for Medicaid eligibility purposes 15
20.01 In general 15
20.02 Correctional facility 16
20.03 Determination of residence in an institution 16
20.04 Homeless individuals 16
20.05 Financial responsibility and living arrangement 17
21.00 Residency 17
21.01 In general 17
21.02 Incapability of indicating intent 17
21.03 Who is a state resident 17

21.04 Placement by a state in an out-of-state institution 17
21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD) 18
21.06 An individual age 21 and over 18
21.07 An individual receiving Title IV-E payments 19
21.08 An individual under age 21 19
21.09 Specific prohibitions 20
21.10 Interstate agreements 20
21.11 Cases of disputed residency 21
21.12 Special rule for tax households with members in multiple Exchange service areas 21
21.13 Temporary absences from the state 21
21.14 Vermont residence as Medicaid payment requirement 22
22.00 [Reserved] 22
23.00 Minimum essential coverage 22
23.01 Minimum essential coverage 22
23.02 Affordable coverage for employer-sponsored MEC 27
23.03 Minimum value for employer-sponsored MEC 30
23.04 Enrollment in eligible employer-sponsored plan 30
23.05 Special eligibility rules 31
23.06 Eligibility determinations for MEC exemptions 32

Part Three
Nonfinancial eligibility requirements

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

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

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

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

(a) In general

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

(2) AHS will advise the individual of:

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

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

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

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

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

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

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

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

[1] 42 CFR § 435.910.

(b) Exception

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

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

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

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

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

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

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

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

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

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

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

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

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

[2] 42 CFR § 435.907(e)(3).

[3] 45 CFR § 155.310(a)(3).

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

17.00 Citizenship and immigration status[5] (01/01/2027~~01/01/2026~~, GCR 26-053~~25-052~~)

17.01 Definitions (01/01/2027~~01/01/2026~~, GCR 26-053~~25-052~~)

(a) U.S. Citizen

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

(2) A naturalized citizen; or

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

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

(c) National[7]

(1) An individual who:

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

[4] 45 CFR § 155.305(f)(6).

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

Effective October 1, 2026, federal financial participation (FFP) for Medicaid coverage of non-citizens is limited under federal law to non-citizens who have these immigration statuses: lawful permanent residents, Cuban and Haitian entrants, individuals lawfully residing under a Compact of Free Association (COFA) and lawfully residing children under age 21 and pregnant individuals covered under § 17.03(c)(6). Pub. L. No. 119-21, § 71109 (2025). Nothing in this rule alters the underlying Medicaid eligibility rules based on citizenship or immigration status under federal law, including the definitions of qualified non-citizen and the applicability of the five-year bar. Rather, this rule identifies which immigration statuses remain eligible for federally funded Medicaid coverage and the applicability of the five-year bar. Vermont Medicaid provides Medicaid only to non-citizens who have immigration statuses for which FFP is available. Eligibility for emergency medical services, as described in § 17.02(d), is unchanged.

[6] 42 CFR § 435.4.

[7] 8 USC § 1101(a)(22).

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

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

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

(d) Qualified non-citizen means

(1) A "Qualified alien," as defined in ~~§§~~ 8 USC §§ 1641(b) and (c), who is:

(i) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [8 USC § 1101 et seq.];

(ii) A non-citizen who is granted asylum under §~~section~~ 208 of such Act [8 USC § 1158];

(iii) A refugee who is admitted to the United States under § ~~section~~ 207 of such Act [8 USC § 1157];

(iv) A non-citizen who is paroled into the United States under §~~section~~ 212(d)(5) of such Act [8 USC § 1182(d)(5)] for a period of at least 1 year;

(v) A non-citizen whose deportation is being withheld under §~~section~~ 243(h) of such Act [8 USC § 1253] (as in effect immediately before the effective date of §~~section~~ 307 of division C of Public Law 104-208) or §~~section~~ 241(b)(3) of such Act [8 USC § 1231(b)(3)] (as amended by §~~section~~ 305(a) of division C of Public Law 104-208);

(vi) A non-citizen who is granted conditional entry pursuant to §~~section~~ 203(a)(7) of such Act [8 USC § 1153(a)(7)] as in effect prior to April 1, 1980;

(vii) A non-citizen who is a Cuban and Haitian entrant (as defined in §~~section~~ 501(e) of the Refugee Education Assistance Act of 1980);

(viii) An individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in 8 USC § 1612(b)(2)(G)[8];

(ix) A non-citizen who

(A) Has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the non-citizen and the spouse or parent consented to, or acquiesced in, such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Has been approved or has a petition pending which sets forth a prima facie case for

(I) Status as a spouse or a child of a United States citizen pursuant to clause (ii), (iii), or (iv) of §~~section~~ 204(a)(1)(A) of the Immigration and Nationality Act [8 USC §

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

1154(a)(1)(A)(ii), (iii), (iv)];

(II) Classification pursuant to clause (ii) or (iii) of §section 204(a)(1)(B) of the Act [8 USC § 1154(a)(1)(B)(ii), (iii)];

(III) Suspension of deportation under §section 244(a)(3) of the Immigration and Nationality Act [8 USC § 1254(a)(3)] (as in effect before the title III-A effective date in §section 309 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996);

(IV) Status as a spouse or child of a United States citizen pursuant to clause (i) of §section 204(a)(1)(A) of such Act [8 USC § 1154(a)(1)(A)(i)], or classification pursuant to clause (i) of §section 204(a)(1)(B) of such Act [8 USC § 1154(a)(1)(B)(i)]; or

(V) Cancellation of removal pursuant to §section 240A(b)(2) of such Act [8 USC § 1229b(b)(2)];

(x) A non-citizen

(A) Whose child has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the non-citizen (without the active participation of the non-citizen in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the non-citizen and the spouse or parent consented or acquiesced to such battery or cruelty, and the non-citizen did not actively participate in such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Who meets the requirement of 8 USC § 1641(c)(1)(B);

(xi) A non-citizen child who

(A) Resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented to or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Who meets the requirement of 8 USC § 1641(c)(1)(B); or

(xii) A non-citizen who has been granted nonimmigrant status under §section 101(a)(15)(T) of the Immigration and Nationality Act [8 USC § 1101(a)(15)(T)] or who has a pending application that sets forth a prima facie case for eligibility for such nonimmigrant status.

(2) Non-citizens who are treated as refugees under other Federal statutes:

(i) Non-citizens who are victims of a severe form of trafficking in persons, as described in 22 USC § 7105(b)(1)(C), or who are classified as nonimmigrants under §section 101(a)(15)(T)(ii) of the Immigration and Nationality Act (8 USC § 1101(a)(15)(T)(ii)), pursuant to 22 USC § 7105(b)(1)(A);

(ii) Iraqi and Afghan special immigrants, as described in Public Law 110-181, §section 1244(g) (2008), Public Law 111-8, §section 602(b)(8) (2009), Public Law 111-118, §section 8120(b) (2010), and Public Law 113-291, §section 1227 (2014);

(iii) Amerasian immigrants, described in Public Law 100-202, §~~section~~ 101(e) (8 USC § 1101 note);

(iv) Certain Afghan parolees, in accordance with §~~Section~~ 2502 of Public Law 117-43, as amended; and

(v) Certain Ukrainian parolees, in accordance with §~~Section~~ 401 of Public Law 117-128, as amended.

(e) [Reserved]

(f) [Reserved]

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

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

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

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

(4) Is granted temporary resident status in accordance with 8 USC § 1160 or § 1255a;

(5) Is granted Temporary Protected Status (TPS) in accordance with 8 USC § 1254a;

(6) Is granted employment authorization under 8 CFR § 274a.12(c);

(7) Is a Family Unity beneficiary in accordance with § 301 of Public Law 101-649, as amended; or §~~section~~ 1504 of the LIFE Act Amendments of 2000, T~~t~~itle XV of H.R. 5666, enacted by reference in Public Law 106-554 (see § 1504 of App. D to Pub L. 106-554);

(8) Is covered by Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(9) Is granted deferred action, except as described at subsection (16) below;

(10) Has a pending application for adjustment of status;

(11) Is an individual:

(i) With a pending application for asylum under 8 USC § 1158 for withholding of removal under 8 USC § 1231(b)(3)(A), or for relief under the Convention Against Torture; and

(ii) Under the age of 14;

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

(13) Has a pending or approved petition for Special Immigrant Juvenile classification as described in 8 USC § 1101(a)(27)(J).

(14) [Reserved]

(15) [Reserved]

(16) *Exception*. An individual with deferred action under DHS's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012, memorandum and 8 CFR § 236.22, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (13) of this definition.[9]

(h) Non-citizen.[10] Has the same meaning as the term "alien," as defined in §~~section~~ 101(a)(3) of the INA, (8 USC § 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 USC § 1101(a)(22).

(i) Eligible non-citizen means[11]

(1) A lawful permanent resident under the Immigration and Nationality Act [8 USC § 1101 et seq.];

(2) An individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in 8 USC § 1612(b)(2)(G); or

~~(h)~~(3) A Cuban or Haitian entrant (as defined in § 501(e) of the Refugee Education Assistance Act of 1980).

17.02 General Rules (01/01/2027~~01/01/2026~~, GCR 26-053~~25-052~~)

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

(b) Enrollment in Medicaid. Effective October 1, 2026, A~~a~~n individual who is a non-citizen is eligible for Medicaid if the individual otherwise satisfies the eligibility requirements and is:

(1) A non-citizen who is under age 21 or pregnant, as described in § 17.03(c)(6), and who is not subject to the five-year bar, regardless of whether the individual is a qualified non-citizen; or

(2) An eligible non-citizen, as defined in § 17.01(i), who is also:

---

[9] 45 CFR § 155.20.

[10] 42 CFR § 435.4.

[11] Pub. L. No. 119-21, § 71109 (2025). This rule's use of the term "eligible non-citizen" aligns with the term "FFP-eligible noncitizen" used by CMS in SHO Letter No. 26-001 (April 8, 2026), p. 4. CMS refers to individuals excluded from federal financial participation, effective October 1, 2026, as "not FFP-eligible noncitizens." Id. at p. 10.

~~(1)~~(i) A qualified non-citizen who:

~~(i)~~(A) Is subject to the five-year bar on Medicaid enrollment at § 17.03(a); and

~~(ii)~~(B) Has exceeded the five-~~-~~year bar~~waiting period~~;

~~(2)~~(ii) A qualified non-citizen who is not subject to the five-year bar under § 17.03(b); or

~~(3)~~(iii) A non-citizen who is not subject to the five-year bar under § 17.03(c), regardless of whether the individual is a qualified non-citizen.

(c) Enrollment in a QHP~~, with or without APTC or CSR~~. An individual who is a non-citizen who is lawfully present in the United States is eligible for enrollment in a QHP~~, with or without APTC or CSR,~~ if the individual otherwise satisfies the eligibility requirements for a QHP and is reasonably expected to be a non-citizen who is lawfully present for the entire period for which QHP enrollment is sought. A lawfully-present individual who is eligible to enroll in a QHP may be eligible for APTC and CSR if they are an eligible non-citizen as defined in § 17.01(i).

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

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

(i) Jeopardy to the individual's health;

(ii) Impairment of bodily functions; or

(iii) Dysfunction of any bodily organ or part.

(2) The individual meets all eligibility requirements for Medicaid except that ~~non-qualified~~ non-citizens only seeking coverage of emergency medical services under this section need not present a Social Security number or document immigration status.

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

17.03 Medicaid eligibility of non-citizens including the applicability of the five-year bar (01/01/2027~~01/01/2026~~, GCR 26-053~~25-052~~)

(a) Qualified non-citizens subject to the five~~5~~-year bar.[13] Non-citizens who enter the United States on or after August 22, 1996 as qualified non-citizens, as defined at § 17.01(d), are not eligible to receive Medicaid for five years from the date they enter the country unless the five-year bar is inapplicable to them pursuant to

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

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

paragraph (b) or (c) below. If they are not qualified non-citizens when they enter, the five-year bar begins the date they become a qualified non-citizen. The following qualified non-citizens are subject to the five-year bar unless it is inapplicable to them pursuant to paragraph (b) or (c) below:

(1) Lawful permanent residents (LPRs) as defined at § 17.01(d)(1)(i);

(2) Non-citizens granted parole in the United States for at least one year as defined at § 17.01(d)(1)(iv);

(3) Non-citizens granted conditional entry[14] as defined at § 17.01(d)(1)(vi); and

(4) Battered non-citizens as defined at §§ 17.01(d)(1)(ix) through (xi).

(b) Qualified non-citizens not subject to the five~~5~~-year bar.[15] The following qualified non-citizens, as defined at § 17.01(d), ~~-~~are not subject to the five-year bar:

(1) Refugees as defined at §17.01(d)(1)(iii) and non-citizens treated as refugees as defined at §17.01(d)(2);

(2) Asylees as defined at §17.01(d)(1)(ii);

(3) Cuban and Haitian e~~E~~ntrants as defined at § 17.01(d)(1)(vii);

(4) An individual who has been granted nonimmigrant status under §~~section~~ 1101(a)(15)(T) of the Immigration and Nationality Act or who has a pending application that sets forth a prima facie case for eligibility for such nonimmigrant status as defined at § 17.01(d)(1)(xi);

(5) Non-citizens whose deportation is being withheld as defined at § 17.01(d)(1)(v); and

(6) [Reserved]

(7) [Reserved]

(8) [Reserved]

(9) [Reserved]

(10) [Reserved]

(11) Compact of Free Association migrants as defined at § 17.01(d)(1)(viii).[16]

(c) Non-citizens not subject to the five~~5~~-year bar regardless of whether they are qualified non-citizens. The five-

[14] As a practical matter the five-year bar will never apply to such non-citizens, since, by definition, they entered the United States and obtained qualified non-citizen status prior to August 22, 1996.

[15] 42 CFR § 435.406(a)(2); 8 USC § 1613(b).

[16] Consolidated Appropriations Act of 2021, § 208; 8 USC §§ 1612(b)(2)(G) and 1613(b)(3).

year bar does not apply to the following groups of non-citizens ~~regardless of whether they are qualified non-citizens~~:

(1) Non-citizens who are applying for treatment of an emergency medical condition only[17];

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

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

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

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

(4) Non-citizens who are American Indians who were born in Canada and who are of at least one-half American Indian blood or who are a member of a Federally-recognized Indian tribe[18];

(5) [Reserved]

(6) Non-citizen children under 21 years of age and non-citizen individuals~~women~~ during pregnancy and their post partum period, who are lawfully residing in the United States and otherwise eligible.[19] Lawfully residing means an individual who is a non-citizen who is considered lawfully present pursuant to § 17.01(g) and is a Vermont resident.

(7) Non-citizen children receiving foster care or adoption assistance under Title IV-E of the Social Security Act (Social Security Act § 402(a)(3))[20];

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

(9) Non-citizens who are lawfully residing and are[21]:

[17] 8 USC § 1613(c)(2)(A).

[18] 8 USC § 1612(b)(2)(E). Abenaki is not a Federally-recognized Indian tribe.

[19] § 214, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

[20] 8 USC § 1613(c)(2)(F).

[21] 8 USC §§ 1612(b)(2)(C) and 1613(b)(2).

(i) A veteran (as defined in §§section 101, 1101 or 1301, or as described in §section 107 of Ttitle 38) with a discharge that is characterized as an honorable discharge and not on account of immigration status, and who fulfills minimum active duty service requirements of § 5303A(d) of Ttitle 38; and

(ii) On active duty (other than active duty for training) in the U. S. military; or

(iii) The spouse or unmarried dependent child of an individual described in (i) or (ii) or the unremarried surviving spouse of an individual described in (i) or (ii) who is deceased if the marriage fulfills the requirements of §section 1304 of Ttitle 38.

18.00 Assignment of rights and cooperation requirements for Medicaid (01/01/2026, GCR 25-052)

18.01 In general[22] (01/01/2024, GCR 23-084)

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

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

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

(b) Exceptions. No assignment is required for:

(1) Medicare payments; or

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

18.03 Cooperation in Obtaining Payments (01/01/2024, GCR 23-084)

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

(1) Establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating as described in § 18.04 or is a pregnant woman described at § 3.00; and

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

[22] 42 CFR § 435.610.

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

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

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

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

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

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

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

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

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

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

(ii) For whom adoption proceedings are pending; or

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

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

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

18.05 Enrollment in a health insurance plan (01/01/2026, GCR 25-052)

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

be considered an entitlement for any individual.

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

(c) For the purposes of this subsection and MCSR 7108.1, a group health insurance plan is a plan that meets the definition of a group health insurance plan specified in 8 V.S.A. § 4041. An individual health insurance plan is a plan that does not meet that definition.

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

19.01 In general[23] (01/15/2017, GCR 16-096)

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

19.02 Exception[24] (01/15/2017, GCR 16-096)

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

20.00 Living arrangements for Medicaid eligibility purposes (01/01/2026, GCR 25-052)

20.01 In general (01/01/2024, GCR 23-084)

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

(a) Their own home;

(b) The household of another; or

(c) The following public institutions:

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

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

(ii) Age 65 or older.

[23] 26 CFR § 1.36B-2(a)(4); 45 CFR § 155.305(a)(2).

[24] 26 CFR § 1.36B-2(a)(4); See, §§ 1312(f)(1)(B) and 1312(f)(3) of the ACA (42 USC §§ 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-3(b)(2).

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

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

(d) A private facility, if:

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

(2) The facility meets the following criteria:

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

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

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

(3) An individual under the age of 21 or age 65 or older meets the living arrangement requirement if they live at the Brattleboro Retreat. In addition, an individual who is a patient at the facility upon reaching their 21st birthday, has eligibility continued to the date of discharge or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements.

20.02 Correctional facility (01/01/2026, GCR 25-052)

(a) In general.[25] An individual living in a correctional facility, including a juvenile facility, is not precluded from being determined eligible for Medicaid or from retaining their Medicaid eligibility if they were eligible before becoming incarcerated. However, the individual's Medicaid benefits will be suspended during their incarceration period (described in (b) below).

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

(c) Inpatient exception: Transfer to a medical facility.[26] While incarcerated, Medicaid is available when a Medicaid enrollee is an inpatient in a medical institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.

[25] 42 CFR §§ 435.1009 and 435.1010.

[26] 42 CFR §§ 435.1009 and 435.1010. This is also based on various letters from CMS to states, inquiring about the availability of federal funds participation for inmate inpatient health care.

(d) Reentry Demonstration Initiative exception: If incarcerated in a participating correctional facility, pre-release services are available to a qualifying Medicaid enrollee within 90 days of the enrollee's expected release from the correctional facility. A participating correctional facility is one that participates in the Reentry Demonstration Initiative under AHS's Global Commitment to Health Section 1115 Waiver.

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

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

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

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

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

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

21.00 Residency (01/01/2024, GCR 23-084)

21.01 In general[27] (01/15/2017, GCR 16-096)

AHS will provide health benefits to an eligible Vermont resident.

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

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

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

(b) Is judged legally incompetent; or

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

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

A resident of the state is any individual who:

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

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

[27] 42 CFR § 435.403; 45 CFR § 155.305(a)(3). Note: The Exchange rules speak in terms of residence within the Exchange's "service area." However, as there will be a single "service area" in Vermont, for both Medicaid and QHP enrollment, this rule speaks in terms of residence within the state.

21.04 Placement by a state in an out-of-state institution[28] (01/01/2023, GCR 22-031)

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

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

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

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

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

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

21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD)[29] (01/01/2024, GCR 23-084)

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

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

21.06 An individual age 21 and over[30] (01/01/2024, GCR 23-084)

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[28] 42 CFR § 435.403(e).

[29] Effective January l, l974, the major portion of Vermont's federal-state program of AABD became the federal program of Supplemental Security Income (SSI) through amendment of title XVI of the Social Security Act. SSI guarantees a minimum national standard of assistance to aged, blind or disabled persons at full federal expense. Vermont supplements the SSI payment with a state-funded payment. While, federal government abandoned the AABD program title, Vermont has retained this name for this state supplementary payment. See, AABD Rule 2700.

[30] 42 CFR § 435.403(h); 45 CFR §§ 155.305(a)(3)(i) and (iii).

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

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

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

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

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

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

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

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

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

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

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

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

21.07 An individual receiving Title IV-E payments[31] (01/01/2023, GCR 22-031)

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

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

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

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

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

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

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

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

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

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

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

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

AHS will not:

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

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

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

[33] 42 CFR § 435.403(j).

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

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

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

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

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

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

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

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

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

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

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

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

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

[36] 45 CFR § 155.305(a)(3)(iv).

[37] 45 CFR § 155.305(a)(3)(v).

of:

(1) Visiting;

(2) Obtaining necessary medical care;

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

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

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

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

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

22.00 [Reserved] (01/01/2025, GCR 24-076)

23.00 Minimum essential coverage (01/01/2026, GCR 25-052)

23.01 Minimum essential coverage (01/01/2026, GCR 25-052)

(a) In general.[40] Minimum essential coverage means coverage under any of the following: Government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, individual health plans and certain other health-benefits coverage.

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

In addition, individuals who are eligible to enroll in health coverage that qualifies as MEC under this section are not eligible to receive federal tax credits and cost-sharing reductions if they enroll in a QHP. See §§ 23.01(b) through 23.01(e) for details on health coverage that qualifies as MEC for purposes of considering eligibility for the federal premium tax credit. As stated in § 23.01(c)(2), for an employer-sponsored plan to be considered as

[38] 42 CFR § 435.403(j)(3).

[39] 42 CFR § 431.52.

[40] 26 USC § 5000A(f); 26 CFR § 1.36B-2(c).

MEC when an employee or related individual applies for APTC, the plan must be affordable and meet minimum value criteria. See § 23.02 for details on affordability, and § 23.03 for details on minimum value.

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

(b) Government-sponsored MEC

(1) In general.[41] Subject to the limitation in paragraph (b)(2), an individual is eligible for government-sponsored MEC for purpose of considering eligibility for the federal premium tax credit if, as of the first day of the first full month the individual may receive benefits under the program, the individual meets the criteria for coverage under one of the following government-sponsored programs:

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

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

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

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

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

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

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

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

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

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

(2) Obligation to complete administrative requirements to obtain coverage.[42] An individual who meets the eligibility criteria for government-sponsored MEC must complete the requirements necessary to receive

[41] 26 USC § 5000A(f)(1)(A); 26 CFR § 1.36B-2(c)(2)(i)

[42] 26 CFR § 1.36B-2(c)(2)(ii).

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

(3) Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, USC §.[43] An individual is eligible for MEC under a health-care program under chapter 17 or 18 of Title 38, USC section only if the individual is enrolled in a health-care program under chapter 17 or 18 of Title 38, USC section identified as MEC in regulations issued under § 5000A of the Code.

(4) Retroactive effect of eligibility determination.[44] If an individual receiving APTC is determined to be eligible for government-sponsored MEC that is effective retroactively (such as Medicaid), the individual is treated as eligible for MEC under that program no earlier than the first day of the first calendar month beginning after the approval.

(5) Determination of Medicaid or CHIP ineligibility.[45] An individual is treated as not eligible for Medicaid or a similar program for a period of coverage under a QHP if, when the individual enrolls in the QHP, the individual is determined to be not eligible for Medicaid or a similar program.

(6) Examples.[46] The following examples illustrate the provisions of this paragraph (b):

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

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

[43] 26 CFR § 1.36B-2(c)(2)(iii).

[44] 26 CFR § 1.36B-2(c)(2)(iv).

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

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

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

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

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

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

(c) Employer-sponsored MEC

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

(2) In general.[47] An employee and related individual who may enroll in an eligible employer-sponsored plan are eligible for MEC under the plan for purposes of considering eligibility for the federal premium tax credit for any month only if the plan is affordable (§ 23.02) and provides minimum value (§ 23.03). Government-sponsored programs described in paragraph (b) of this subsection are not eligible employer-sponsored plans.

(3) Plan year.[48] For purposes of this paragraph, a plan year is an eligible employer-sponsored plan's regular

[47] 26 CFR § 1.36B-2(c)(3)(i).

[48] 26 CFR § 1.36B-2(c)(3)(ii).

12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).

(4) Eligibility for months during a plan year

(i) Failure to enroll in plan.[49] An employee or related individual may be eligible for MEC under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

(ii) Waiting periods.[50] An employee or related individual is not eligible for MEC under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.

(iii) Example.[51] The following example illustrates the provisions of this paragraph (c)(4):

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

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

(5) Post-employment coverage.[52] A former employee (including a retiree), or an individual related (within the meaning of this paragraph (c)) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for MEC under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(d) Other coverage that qualifies as MEC. The following types of coverage are designated as MEC for purposes of

[49] 26 CFR § 1.36B-2(c)(3)(iii)(A).

[50] 26 CFR § 1.36B-2(c)(3)(iii)(B).

[51] 26 CFR § 1.36B-2(c)(3)(iii)(C).

[52] 26 CFR § 1.36B-2(c)(3)(iv).

considering eligibility for the federal premium tax credit[53]:

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

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

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

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

(e) Eligibility based on enrollment.[54] An individual is eligible for MEC under the following programs for purposes of considering eligibility for the federal premium tax credit only if the individual is enrolled in the coverage:

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

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

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

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

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

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

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

(iv) Reserve Select (10 USC § 1076d).

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

[53] 26 USC § 5000A(f)(1)(E).

[54] See, IRS Notice 2013-41.

became pregnant.[55]

23.02 Affordable coverage for employer-sponsored MEC (01/01/2023, GCR 22-031)

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

(a) In general

(1) Affordability for employee.[56] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)) of the applicable tax filer's household income for the benefit year.

(2) Affordability for related individual.[57] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for a related individual if the employee's required contribution for family coverage under the plan does not exceed the required contribution percentage, as defined in paragraph (c) of this subsection, of the applicable tax filer's household income for the benefit year. For purposes of this paragraph (a)(2), an employee's required contribution for family coverage is the portion of the annual premium the employee must pay for coverage of the employee and all other individuals included in the employee's family who are offered coverage under the eligible employer-sponsored plan.

(3) Employee safe harbor.[58] An employee or a related individual who is eligible for a safe harbor as defined in this sub clause will not be subject to repayment of APTC based on the finding that affordable MEC was in fact available to them for all or part of a plan year, should such fact be discovered at a time subsequent to enrollment in a QHP.

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

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

(iii) This paragraph does not apply for an individual who, with reckless disregard for the facts, provides

[55] See, IRS Notice 2014-71.

[56] 26 CFR § 1.36B-2(c)(3)(v)(A)(1).

[57] 26 CFR § 1.36B-2(c)(3)(v)(A)(2).

[58] 26 CFR § 1.36B-2(c)(3)(v)(A)(3).

incorrect information concerning the portion of the annual premium for coverage for the employee or related individual under the plan.

(4) Wellness program incentives.[59] Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this subsection, the term "wellness program incentive" has the same meaning as the term "reward" in 26 CFR § 54.9802-1(f)(1)(i).

(5) Employer contributions to health reimbursement arrangements.[60] Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in IRS Notice 2013-54 (2013-40 IRB 287), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(6) Employer contributions to cafeteria plans.[61] Amounts made available for the current plan year under a cafeteria plan, within the meaning of 26 USC § 125, reduce an employee's or a related individual's required contribution if:

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

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

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

(7) [Reserved]

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

[59] 26 CFR § 1.36B-2(c)(3)(v)(A)(4).

[60] 26 CFR § 1.36B-2(c)(3)(v)(A)(5).

[61] 26 CFR § 1.36B-2(c)(3)(v)(A)(6).

subsection.

(b) Affordability for part-year period.[62] Affordability under paragraph (a)(1) of this subsection is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different benefit years of an applicable tax filer (a part-year period). Coverage under an eligible employer-sponsored plan is affordable for a part-year period if the annualized required contribution for self-only coverage, in the case of an employee, or family coverage, in the case of a related individual, under the plan for the part-year period does not exceed the required contribution percentage of the applicable tax filer's household income for the benefit year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable tax filer's benefit year. Only full calendar months are included in the computation under this paragraph.

(c) Required contribution percentage.[63] The required contribution percentage for 2014 is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under IRS-published guidance. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

(d) Examples.[64] For examples illustrating these provisions, see 26 CFR § 1.36B-2(c)(3)(v)(D).

23.03 Minimum value for employer-sponsored MEC[65] (01/15/2017, GCR 16-096)

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

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

(a) In general.[66] Except as provided in paragraph (b) of this subsection, the requirements of affordability and

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[62] 26 CFR § 1.36B-2(c)(3)(v)(B).

[63] 26 CFR § 1.36B-2(c)(3)(v)(C). For plan years after 2014, the required contribution percentage will be updated in accordance with IRS-published guidance, available at www.irs.gov. For example, the required contribution percentage for 2016 is located at: https://www.irs.gov/pub/irs-drop/rp-14-62.pdf.

[64] 26 CFR § 1.36B-2(c)(3)(v)(D).

[65] 45 CFR § 156.145; see, also, 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

[66] 26 CFR § 1.36B-2(c)(3)(vii)(A).

minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.

(b) Automatic enrollment.[67] An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.

(c) Examples.[68] The following examples illustrate the provisions of this subsection:

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

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

(3) Example 3. The facts are the same as in Example 1, except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (b) of this subsection, H is not eligible for MEC under X's plan for January 2015.

23.05 Special eligibility rules[69] (01/01/2018, GCR 17-045)

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

(b) VHC unable to discontinue APTC

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

[67] 26 CFR § 1.36B-2(c)(3)(vii)(B).

[68] 26 CFR § 1.36B-2(c)(3)(vii)(C).

[69] 26 CFR § 1.36B-2(c)(4).

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

23.06 Eligibility determinations for MEC exemptions[70] (01/01/2018, GCR 17-045)

(a) In general.[71] AHS will satisfy the requirement to determine eligibility for an exemption from the shared responsibility payment by adopting an exemption eligibility determination made by HHS.

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

[71] 45 CFR § 155.625. Exemption applications and instructions are located at www.healthcare.gov/health-coverage-exemptions.

VERMONT LEGAL AID

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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
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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.

Table of Contents

Part Three Nonfinancial eligibility requirements 1

15.00 Nonfinancial eligibility requirements, in general 1

16.00 Social Security number 1

16.01 Medicaid 1

16.02 QHP 2

17.00 Citizenship and immigration status 3

17.01 Definitions 3

17.02 General Rules 7

17.03 Medicaid eligibility of non-citizens including the applicability of the five-year bar 8

18.00 Assignment of rights and cooperation requirements for Medicaid 11

18.01 In general 11

18.02 Assignment of rights to payments 11

18.03 Cooperation in Obtaining Payments 11

18.04 Good cause for noncooperation 12

18.05 Enrollment in a health insurance plan 12

19.00 Incarceration and QHP eligibility 13

19.01 In general 13

19.02 Exception 13

20.00 Living arrangements for Medicaid eligibility purposes 13

20.01 In general 13

20.02 Correctional facility 14

20.03 Determination of residence in an institution 15

20.04 Homeless individuals 15

20.05 Financial responsibility and living arrangement 15

21.00 Residency 15
21.01 In general 15
21.02 Incapability of indicating intent 15
21.03 Who is a state resident 15
21.04 Placement by a state in an out-of-state institution 16
21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD) 16
21.06 An individual age 21 and over 16
21.07 An individual receiving Title IV-E payments 17
21.08 An individual under age 21 18
21.09 Specific prohibitions 18
21.10 Interstate agreements 19
21.11 Cases of disputed residency 19
21.12 Special rule for tax households with members in multiple Exchange service areas 19
21.13 Temporary absences from the state 19
21.14 Vermont residence as Medicaid payment requirement 20
22.00 [Reserved] 20
23.00 Minimum essential coverage 20
23.01 Minimum essential coverage 20
23.02 Affordable coverage for employer-sponsored MEC 26
23.03 Minimum value for employer-sponsored MEC 28
23.04 Enrollment in eligible employer-sponsored plan 28
23.05 Special eligibility rules 29
23.06 Eligibility determinations for MEC exemptions 30

Part Three
Nonfinancial eligibility requirements

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

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

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

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

(a) In general

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

(2) AHS will advise the individual of:

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

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

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

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

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

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

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

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

[1] 42 CFR § 435.910.

(b) Exception

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

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

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

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

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

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

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

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

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

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

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

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

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

[2] 42 CFR § 435.907(e)(3).

[3] 45 CFR § 155.310(a)(3).

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

17.00 Citizenship and immigration status[5] (01/01/2027, GCR 26-053)

17.01 Definitions (01/01/2027, GCR 26-053)

(a) U.S. Citizen

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

(2) A naturalized citizen; or

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

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

(c) National[7]

(1) An individual who:

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

[4] 45 CFR § 155.305(f)(6).

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

Effective October 1, 2026, federal financial participation (FFP) for Medicaid coverage of non-citizens is limited under federal law to non-citizens who have these immigration statuses: lawful permanent residents, Cuban and Haitian entrants, individuals lawfully residing under a Compact of Free Association (COFA) and lawfully residing children under age 21 and pregnant individuals covered under § 17.03(c)(6). Pub. L. No. 119-21, § 71109 (2025). Nothing in this rule alters the underlying Medicaid eligibility rules based on citizenship or immigration status under federal law, including the definitions of qualified non-citizen and the applicability of the five-year bar. Rather, this rule identifies which immigration statuses remain eligible for federally funded Medicaid coverage and the applicability of the five-year bar. Vermont Medicaid provides Medicaid only to non-citizens who have immigration statuses for which FFP is available. Eligibility for emergency medical services, as described in § 17.02(d), is unchanged.

[6] 42 CFR § 435.4.

[7] 8 USC § 1101(a)(22).

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

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

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

(d) Qualified non-citizen means

(1) A "Qualified alien," as defined in 8 USC §§ 1641(b) and (c), who is:

(i) A non-citizen who is lawfully admitted for permanent residence under the Immigration and Nationality Act [8 USC § 1101 et seq.];

(ii) A non-citizen who is granted asylum under § 208 of such Act [8 USC § 1158];

(iii) A refugee who is admitted to the United States under § 207 of such Act [8 USC § 1157];

(iv) A non-citizen who is paroled into the United States under § 212(d)(5) of such Act [8 USC § 1182(d)(5)] for a period of at least 1 year;

(v) A non-citizen whose deportation is being withheld under § 243(h) of such Act [8 USC § 1253] (as in effect immediately before the effective date of § 307 of division C of Public Law 104-208) or § 241(b)(3) of such Act [8 USC § 1231(b)(3)] (as amended by § 305(a) of division C of Public Law 104-208);

(vi) A non-citizen who is granted conditional entry pursuant to § 203(a)(7) of such Act [8 USC § 1153(a)(7)] as in effect prior to April 1, 1980;

(vii) A non-citizen who is a Cuban and Haitian entrant (as defined in § 501(e) of the Refugee Education Assistance Act of 1980);

(viii) An individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in 8 USC § 1612(b)(2)(G)[8];

(ix) A non-citizen who

(A) Has been battered or subjected to extreme cruelty in the United States by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the non-citizen and the spouse or parent consented to, or acquiesced in, such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Has been approved or has a petition pending which sets forth a prima facie case for

(I) Status as a spouse or a child of a United States citizen pursuant to clause (ii), (iii), or (iv) of § 204(a)(1)(A) of the Immigration and Nationality Act [8 USC § 1154(a)(1)(A)(ii), (iii),

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

(iv)];

(II) Classification pursuant to clause (ii) or (iii) of § 204(a)(1)(B) of the Act [8 USC § 1154(a)(1)(B)(ii), (iii)];

(III) Suspension of deportation under § 244(a)(3) of the Immigration and Nationality Act [8 USC § 1254(a)(3)] (as in effect before the title III-A effective date in § 309 of the Illegal Immigration Reform and Immigrant Responsibility Act of 1996);

(IV) Status as a spouse or child of a United States citizen pursuant to clause (i) of § 204(a)(1)(A) of such Act [8 USC § 1154(a)(1)(A)(i)], or classification pursuant to clause (i) of § 204(a)(1)(B) of such Act [8 USC § 1154(a)(1)(B)(i)]; or

(V) Cancellation of removal pursuant to § 240A(b)(2) of such Act [8 USC § 1229b(b)(2)];

(x) A non-citizen

(A) Whose child has been battered or subjected to extreme cruelty in the United States by a spouse or a parent of the non-citizen (without the active participation of the non-citizen in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the non-citizen and the spouse or parent consented or acquiesced to such battery or cruelty, and the non-citizen did not actively participate in such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Who meets the requirement of 8 USC § 1641(c)(1)(B);

(xi) A non-citizen child who

(A) Resides in the same household as a parent who has been battered or subjected to extreme cruelty in the United States by that parent's spouse or by a member of the spouse's family residing in the same household as the parent and the spouse consented to or acquiesced to such battery or cruelty, but only if (in the opinion of the agency providing such benefits) there is a substantial connection between such battery or cruelty and the need for the benefits to be provided; and

(B) Who meets the requirement of 8 USC § 1641(c)(1)(B); or

(xii) A non-citizen who has been granted nonimmigrant status under § 101(a)(15)(T) of the Immigration and Nationality Act [8 USC § 1101(a)(15)(T)] or who has a pending application that sets forth a prima facie case for eligibility for such nonimmigrant status.

(2) Non-citizens who are treated as refugees under other Federal statutes:

(i) Non-citizens who are victims of a severe form of trafficking in persons, as described in 22 USC § 7105(b)(1)(C), or who are classified as nonimmigrants under § 101(a)(15)(T)(ii) of the Immigration and Nationality Act (8 USC § 1101(a)(15)(T)(ii)), pursuant to 22 USC § 7105(b)(1)(A);

(ii) Iraqi and Afghan special immigrants, as described in Public Law 110-181, § 1244(g) (2008), Public Law 111-8, § 602(b)(8) (2009), Public Law 111-118, § 8120(b) (2010), and Public Law 113-291, § 1227 (2014);

(iii) Amerasian immigrants, described in Public Law 100-202, § 101(e) (8 USC § 1101 note);

(iv) Certain Afghan parolees, in accordance with § 2502 of Public Law 117-43, as amended; and

(v) Certain Ukrainian parolees, in accordance with § 401 of Public Law 117-128, as amended.

(e) [Reserved]

(f) [Reserved]

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

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

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

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

(4) Is granted temporary resident status in accordance with 8 USC § 1160 or § 1255a;

(5) Is granted Temporary Protected Status (TPS) in accordance with 8 USC § 1254a;

(6) Is granted employment authorization under 8 CFR § 274a.12(c);

(7) Is a Family Unity beneficiary in accordance with § 301 of Public Law 101-649, as amended; or § 1504 of the LIFE Act Amendments of 2000, Title XV of H.R. 5666, enacted by reference in Public Law 106-554 (see § 1504 of App. D to Pub L. 106-554);

(8) Is covered by Deferred Enforced Departure (DED) in accordance with a decision made by the President;

(9) Is granted deferred action, except as described at subsection (16) below;

(10) Has a pending application for adjustment of status;

(11) Is an individual:

(i) With a pending application for asylum under 8 USC § 1158 for withholding of removal under 8 USC § 1231(b)(3)(A), or for relief under the Convention Against Torture; and

(ii) Under the age of 14;

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

(13) Has a pending or approved petition for Special Immigrant Juvenile classification as described in 8 USC § 1101(a)(27)(J).

(14) [Reserved]

(15) [Reserved]

(16) *Exception*. An individual with deferred action under DHS's deferred action for childhood arrivals process, as described in the Secretary of Homeland Security's June 15, 2012, memorandum and 8 CFR § 236.22, shall not be considered to be lawfully present with respect to any of the above categories in paragraphs (1) through (13) of this definition.[9]

(h) Non-citizen.[10] Has the same meaning as the term "alien," as defined in § 101(a)(3) of the INA, (8 USC § 1101(a)(3)) and includes any individual who is not a citizen or national of the United States, defined at 8 USC § 1101(a)(22).

(i) Eligible non-citizen means[11]

(1) A lawful permanent resident under the Immigration and Nationality Act [8 USC § 1101 et seq.];

(2) An individual who lawfully resides in the United States in accordance with a Compact of Free Association referred to in 8 USC § 1612(b)(2)(G); or

(3) A Cuban or Haitian entrant (as defined in § 501(e) of the Refugee Education Assistance Act of 1980).

17.02 General Rules (01/01/2027, GCR 26-053)

(a) Health benefits, in general. As a condition of eligibility for health benefits, an individual must be a citizen, a national of the United States or a non-citizen who meets the requirements in paragraphs (b) through (d) of this subsection. For purposes of enrollment in a QHP, the individual must reasonably expect to be a citizen, a national or a non-citizen who is lawfully present for the entire period for which QHP enrollment is sought.

(b) Enrollment in Medicaid. Effective October 1, 2026, an individual who is a non-citizen is eligible for Medicaid if the individual otherwise satisfies the eligibility requirements and is:

(1) A non-citizen who is under age 21 or pregnant, as described in § 17.03(c)(6), and who is not subject to the five-year bar, regardless of whether the individual is a qualified non-citizen; or

(2) An eligible non-citizen, as defined in § 17.01(i), who is also:

(i) A qualified non-citizen who:

(A) Is subject to the five-year bar on Medicaid enrollment at § 17.03(a); and

[9] 45 CFR § 155.20.

[10] 42 CFR § 435.4.

[11] Pub. L. No. 119-21, § 71109 (2025). This rule's use of the term "eligible non-citizen" aligns with the term "FFP-eligible noncitizen" used by CMS in SHO Letter No. 26-001 (April 8, 2026), p. 4. CMS refers to individuals excluded from federal financial participation, effective October 1, 2026, as "not FFP-eligible noncitizens." Id. at p. 10.

(B) Has exceeded the five-year bar;

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

(iii) A non-citizen who is not subject to the five-year bar under § 17.03(c), regardless of whether the individual is a qualified non-citizen.

(c) Enrollment in a QHP. An individual who is a non-citizen who is lawfully present in the United States is eligible for enrollment in a QHP if the individual otherwise satisfies the eligibility requirements for a QHP and is reasonably expected to be a non-citizen who is lawfully present for the entire period for which QHP enrollment is sought. A lawfully-present individual who is eligible to enroll in a QHP may be eligible for APTC and CSR if they are an eligible non-citizen as defined in § 17.01(i).

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

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

(i) Jeopardy to the individual's health;

(ii) Impairment of bodily functions; or

(iii) Dysfunction of any bodily organ or part.

(2) The individual meets all eligibility requirements for Medicaid except that non-citizens only seeking coverage of emergency medical services under this section need not present a Social Security number or document immigration status.

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

17.03 Medicaid eligibility of non-citizens including the applicability of the five-year bar (01/01/2027, GCR 26-053)

(a) Qualified non-citizens subject to the five-year bar.[13] Non-citizens who enter the United States on or after August 22, 1996 as qualified non-citizens, as defined at § 17.01(d), are not eligible to receive Medicaid for five years from the date they enter the country unless the five-year bar is inapplicable to them pursuant to paragraph (b) or (c) below. If they are not qualified non-citizens when they enter, the five-year bar begins the date they become a qualified non-citizen. The following qualified non-citizens are subject to the five-year bar

[12] A lawfully-present individual who is enrolled in a QHP, with or without subsidies, is nevertheless eligible for emergency medical services.

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

unless it is inapplicable to them pursuant to paragraph (b) or (c) below:

(1) Lawful permanent residents (LPRs) as defined at § 17.01(d)(1)(i);

(2) Non-citizens granted parole in the United States for at least one year as defined at § 17.01(d)(1)(iv);

(3) Non-citizens granted conditional entry[14] as defined at § 17.01(d)(1)(vi); and

(4) Battered non-citizens as defined at §§ 17.01(d)(1)(ix) through (xi).

(b) Qualified non-citizens not subject to the five-year bar.[15] The following qualified non-citizens, as defined at § 17.01(d), are not subject to the five-year bar:

(1) Refugees as defined at §17.01(d)(1)(iii) and non-citizens treated as refugees as defined at §17.01(d)(2);

(2) Asylees as defined at §17.01(d)(1)(ii);

(3) Cuban and Haitian entrants as defined at § 17.01(d)(1)(vii);

(4) An individual who has been granted nonimmigrant status under § 1101(a)(15)(T) of the Immigration and Nationality Act or who has a pending application that sets forth a prima facie case for eligibility for such nonimmigrant status as defined at § 17.01(d)(1)(xi);

(5) Non-citizens whose deportation is being withheld as defined at § 17.01(d)(1)(v); and

(6) [Reserved]

(7) [Reserved]

(8) [Reserved]

(9) [Reserved]

(10) [Reserved]

(11) Compact of Free Association migrants as defined at § 17.01(d)(1)(viii).[16]

(c) Non-citizens not subject to the five-year bar regardless of whether they are qualified non-citizens. The five-year bar does not apply to the following groups of non-citizens:

[14] As a practical matter the five-year bar will never apply to such non-citizens, since, by definition, they entered the United States and obtained qualified non-citizen status prior to August 22, 1996.

[15] 42 CFR § 435.406(a)(2); 8 USC § 1613(b).

[16] Consolidated Appropriations Act of 2021, § 208; 8 USC §§ 1612(b)(2)(G) and 1613(b)(3).

(1) Non-citizens who are applying for treatment of an emergency medical condition only[17];

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

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

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

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

(4) Non-citizens who are American Indians who were born in Canada and who are of at least one-half American Indian blood or who are a member of a Federally-recognized Indian tribe[18];

(5) [Reserved]

(6) Non-citizen children under 21 years of age and non-citizen individuals during pregnancy and their post partum period, who are lawfully residing in the United States and otherwise eligible.[19] Lawfully residing means an individual who is a non-citizen who is considered lawfully present pursuant to § 17.01(g) and is a Vermont resident.

(7) Non-citizen children receiving foster care or adoption assistance under Title IV-E of the Social Security Act (Social Security Act § 402(a)(3))[20];

(8) Lawful permanent residents who first entered the United States under another exempt category (e.g., refugee, asylee, Cuban or Haitian entrant, non-citizen whose deportation was being withheld) and who later converted to the lawful permanent resident status; and

(9) Non-citizens who are lawfully residing and are[21]:

(i) A veteran (as defined in §§ 101, 1101 or 1301, or as described in § 107 of Title 38) with a discharge that is characterized as an honorable discharge and not on account of immigration status, and who

[17] 8 USC § 1613(c)(2)(A).

[18] 8 USC § 1612(b)(2)(E). Abenaki is not a Federally-recognized Indian tribe.

[19] § 214, Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

[20] 8 USC § 1613(c)(2)(F).

[21] 8 USC §§ 1612(b)(2)(C) and 1613(b)(2).

fulfills minimum active duty service requirements of § 5303A(d) of Title 38;

(ii) On active duty (other than active duty for training) in the U. S. military; or

(iii) The spouse or unmarried dependent child of an individual described in (i) or (ii) or the unremarried surviving spouse of an individual described in (i) or (ii) who is deceased if the marriage fulfills the requirements of § 1304 of Title 38.

18.00 Assignment of rights and cooperation requirements for Medicaid (01/01/2026, GCR 25-052)

18.01 In general[22] (01/01/2024, GCR 23-084)

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

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

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

(b) Exceptions. No assignment is required for:

(1) Medicare payments; or

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

18.03 Cooperation in Obtaining Payments (01/01/2024, GCR 23-084)

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

(1) Establishing the identity of a child's parents and in obtaining medical support and payments, unless the individual establishes good cause for not cooperating as described in § 18.04 or is a pregnant woman described at § 3.00; and

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

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

[22] 42 CFR § 435.610.

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

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

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

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

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

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

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

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

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

(ii) For whom adoption proceedings are pending; or

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

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

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

18.05 Enrollment in a health insurance plan (01/01/2026, GCR 25-052)

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

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

(c) For the purposes of this subsection and MCSR 7108.1, a group health insurance plan is a plan that meets the definition of a group health insurance plan specified in 8 V.S.A. § 4041. An individual health insurance plan is a plan that does not meet that definition.

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

19.01 In general[23] (01/15/2017, GCR 16-096)

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

19.02 Exception[24] (01/15/2017, GCR 16-096)

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

20.00 Living arrangements for Medicaid eligibility purposes (01/01/2026, GCR 25-052)

20.01 In general (01/01/2024, GCR 23-084)

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

(a) Their own home;

(b) The household of another; or

(c) The following public institutions:

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

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

(ii) Age 65 or older.

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

(3) A facility supported in whole or in part by public funds whose primary purpose is to provide medical care

[23] 26 CFR § 1.36B-2(a)(4); 45 CFR § 155.305(a)(2).

[24] 26 CFR § 1.36B-2(a)(4); See, §§ 1312(f)(1)(B) and 1312(f)(3) of the ACA (42 USC §§ 18032(f)(1)(B) and (f)(3)) and 26 CFR § 1.36B-3(b)(2).

other than the treatment of mental disease, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.

(d) A private facility, if:

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

(2) The facility meets the following criteria:

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

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

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

(3) An individual under the age of 21 or age 65 or older meets the living arrangement requirement if they live at the Brattleboro Retreat. In addition, an individual who is a patient at the facility upon reaching their 21st birthday, has eligibility continued to the date of discharge or their 22nd birthday, whichever comes first, as long as they continue to meet all other eligibility requirements.

20.02 Correctional facility (01/01/2026, GCR 25-052)

(a) In general.[25] An individual living in a correctional facility, including a juvenile facility, is not precluded from being determined eligible for Medicaid or from retaining their Medicaid eligibility if they were eligible before becoming incarcerated. However, the individual's Medicaid benefits will be suspended during their incarceration period (described in (b) below).

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

(c) Inpatient exception: Transfer to a medical facility.[26] While incarcerated, Medicaid is available when a Medicaid enrollee is an inpatient in a medical institution not under the control of the corrections system. Such institutions include a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.

(d) Reentry Demonstration Initiative exception: If incarcerated in a participating correctional facility, pre-release services are available to a qualifying Medicaid enrollee within 90 days of the enrollee's expected release from the correctional facility. A participating correctional facility is one that participates in the Reentry

[25] 42 CFR §§ 435.1009 and 435.1010.

[26] 42 CFR §§ 435.1009 and 435.1010. This is also based on various letters from CMS to states, inquiring about the availability of federal funds participation for inmate inpatient health care.

Demonstration Initiative under AHS's Global Commitment to Health Section 1115 Waiver.

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

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

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

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

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

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

21.00 Residency (01/01/2024, GCR 23-084)

21.01 In general[27] (01/15/2017, GCR 16-096)

AHS will provide health benefits to an eligible Vermont resident.

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

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

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

(b) Is judged legally incompetent; or

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

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

A resident of the state is any individual who:

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

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

[27] 42 CFR § 435.403; 45 CFR § 155.305(a)(3). Note: The Exchange rules speak in terms of residence within the Exchange's "service area." However, as there will be a single "service area" in Vermont, for both Medicaid and QHP enrollment, this rule speaks in terms of residence within the state.

21.04 Placement by a state in an out-of-state institution[28] (01/01/2023, GCR 22-031)

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

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

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

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

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

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

21.05 An individual receiving Aid to the Aged, Blind, and Disabled (AABD)[29] (01/01/2024, GCR 23-084)

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

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

21.06 An individual age 21 and over[30] (01/01/2024, GCR 23-084)

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[28] 42 CFR § 435.403(e).

[29] Effective January l, l974, the major portion of Vermont's federal-state program of AABD became the federal program of Supplemental Security Income (SSI) through amendment of title XVI of the Social Security Act. SSI guarantees a minimum national standard of assistance to aged, blind or disabled persons at full federal expense. Vermont supplements the SSI payment with a state-funded payment. While, federal government abandoned the AABD program title, Vermont has retained this name for this state supplementary payment. See, AABD Rule 2700.

[30] 42 CFR § 435.403(h); 45 CFR §§ 155.305(a)(3)(i) and (iii).

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

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

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

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

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

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

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

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

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

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

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

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

21.07 An individual receiving Title IV-E payments[31] (01/01/2023, GCR 22-031)

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

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

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

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

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

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

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

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

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

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

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

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

AHS will not:

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

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

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

[33] 42 CFR § 435.403(j).

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

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

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

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

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

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

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

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

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

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

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

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

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

[36] 45 CFR § 155.305(a)(3)(iv).

[37] 45 CFR § 155.305(a)(3)(v).

of:

(1) Visiting;

(2) Obtaining necessary medical care;

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

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

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

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

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

22.00 [Reserved] (01/01/2025, GCR 24-076)

23.00 Minimum essential coverage (01/01/2026, GCR 25-052)

23.01 Minimum essential coverage (01/01/2026, GCR 25-052)

(a) In general.[40] Minimum essential coverage means coverage under any of the following: Government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, individual health plans and certain other health-benefits coverage.

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

In addition, individuals who are eligible to enroll in health coverage that qualifies as MEC under this section are not eligible to receive federal tax credits and cost-sharing reductions if they enroll in a QHP. See §§ 23.01(b) through 23.01(e) for details on health coverage that qualifies as MEC for purposes of considering eligibility for the federal premium tax credit. As stated in § 23.01(c)(2), for an employer-sponsored plan to be considered as

[38] 42 CFR § 435.403(j)(3).

[39] 42 CFR § 431.52.

[40] 26 USC § 5000A(f); 26 CFR § 1.36B-2(c).

MEC when an employee or related individual applies for APTC, the plan must be affordable and meet minimum value criteria. See § 23.02 for details on affordability, and § 23.03 for details on minimum value.

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

(b) Government-sponsored MEC

(1) In general.[41] Subject to the limitation in paragraph (b)(2), an individual is eligible for government-sponsored MEC for purpose of considering eligibility for the federal premium tax credit if, as of the first day of the first full month the individual may receive benefits under the program, the individual meets the criteria for coverage under one of the following government-sponsored programs:

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

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

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

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

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

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

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

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

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

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

(2) Obligation to complete administrative requirements to obtain coverage.[42] An individual who meets the eligibility criteria for government-sponsored MEC must complete the requirements necessary to receive

[41] 26 USC § 5000A(f)(1)(A); 26 CFR § 1.36B-2(c)(2)(i)

[42] 26 CFR § 1.36B-2(c)(2)(ii).

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

(3) Special rule for coverage for veterans and other individuals under chapter 17 or 18 of Title 38, USC §.[43] An individual is eligible for MEC under a health-care program under chapter 17 or 18 of Title 38, USC section only if the individual is enrolled in a health-care program under chapter 17 or 18 of Title 38, USC section identified as MEC in regulations issued under § 5000A of the Code.

(4) Retroactive effect of eligibility determination.[44] If an individual receiving APTC is determined to be eligible for government-sponsored MEC that is effective retroactively (such as Medicaid), the individual is treated as eligible for MEC under that program no earlier than the first day of the first calendar month beginning after the approval.

(5) Determination of Medicaid or CHIP ineligibility.[45] An individual is treated as not eligible for Medicaid or a similar program for a period of coverage under a QHP if, when the individual enrolls in the QHP, the individual is determined to be not eligible for Medicaid or a similar program.

(6) Examples.[46] The following examples illustrate the provisions of this paragraph (b):

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

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

[43] 26 CFR § 1.36B-2(c)(2)(iii).

[44] 26 CFR § 1.36B-2(c)(2)(iv).

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

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

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

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

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

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

(c) Employer-sponsored MEC

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

(2) In general.[47] An employee and related individual who may enroll in an eligible employer-sponsored plan are eligible for MEC under the plan for purposes of considering eligibility for the federal premium tax credit for any month only if the plan is affordable (§ 23.02) and provides minimum value (§ 23.03). Government-sponsored programs described in paragraph (b) of this subsection are not eligible employer-sponsored plans.

(3) Plan year.[48] For purposes of this paragraph, a plan year is an eligible employer-sponsored plan's regular

[47] 26 CFR § 1.36B-2(c)(3)(i).

[48] 26 CFR § 1.36B-2(c)(3)(ii).

12-month coverage period (or the remainder of a 12-month coverage period for a new employee or an individual who enrolls during a special enrollment period).

(4) Eligibility for months during a plan year

(i) Failure to enroll in plan.[49] An employee or related individual may be eligible for MEC under an eligible employer-sponsored plan for a month during a plan year if the employee or related individual could have enrolled in the plan for that month during an open or special enrollment period for the plan year. If an enrollment period relates to coverage for not only the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period), but also coverage in one or more succeeding plan years, this paragraph applies only to eligibility for the coverage in the upcoming plan year (or the current plan year in the case of an enrollment period other than an open enrollment period).

(ii) Waiting periods.[50] An employee or related individual is not eligible for MEC under an eligible employer-sponsored plan during a required waiting period before the coverage becomes effective.

(iii) Example.[51] The following example illustrates the provisions of this paragraph (c)(4):

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

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

(5) Post-employment coverage.[52] A former employee (including a retiree), or an individual related (within the meaning of this paragraph (c)) to a former employee, who may enroll in eligible employer-sponsored coverage or in continuation coverage required under federal law or a state law that provides comparable continuation coverage is eligible for MEC under this coverage only for months that the former employee or related individual is enrolled in the coverage.

(d) Other coverage that qualifies as MEC. The following types of coverage are designated as MEC for purposes of

[49] 26 CFR § 1.36B-2(c)(3)(iii)(A).

[50] 26 CFR § 1.36B-2(c)(3)(iii)(B).

[51] 26 CFR § 1.36B-2(c)(3)(iii)(C).

[52] 26 CFR § 1.36B-2(c)(3)(iv).

considering eligibility for the federal premium tax credit[53]:

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

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

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

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

(e) Eligibility based on enrollment.[54] An individual is eligible for MEC under the following programs for purposes of considering eligibility for the federal premium tax credit only if the individual is enrolled in the coverage:

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

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

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

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

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

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

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

(iv) Reserve Select (10 USC § 1076d).

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

[53] 26 USC § 5000A(f)(1)(E).

[54] See, IRS Notice 2013-41.

became pregnant.[55]

23.02 Affordable coverage for employer-sponsored MEC (01/01/2023, GCR 22-031)

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

(a) In general

(1) Affordability for employee.[56] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for an employee if the portion of the annual premium the employee must pay, whether by salary reduction or otherwise (required contribution), for self-only coverage does not exceed the required contribution percentage (as defined in paragraph (c)) of the applicable tax filer's household income for the benefit year.

(2) Affordability for related individual.[57] Except as provided in paragraph (a)(3) of this subsection, an eligible employer-sponsored plan is affordable for a related individual if the employee's required contribution for family coverage under the plan does not exceed the required contribution percentage, as defined in paragraph (c) of this subsection, of the applicable tax filer's household income for the benefit year. For purposes of this paragraph (a)(2), an employee's required contribution for family coverage is the portion of the annual premium the employee must pay for coverage of the employee and all other individuals included in the employee's family who are offered coverage under the eligible employer-sponsored plan.

(3) Employee safe harbor.[58] An employee or a related individual who is eligible for a safe harbor as defined in this sub clause will not be subject to repayment of APTC based on the finding that affordable MEC was in fact available to them for all or part of a plan year, should such fact be discovered at a time subsequent to enrollment in a QHP.

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

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

(iii) This paragraph does not apply for an individual who, with reckless disregard for the facts, provides

[55] See, IRS Notice 2014-71.

[56] 26 CFR § 1.36B-2(c)(3)(v)(A)(1).

[57] 26 CFR § 1.36B-2(c)(3)(v)(A)(2).

[58] 26 CFR § 1.36B-2(c)(3)(v)(A)(3).

incorrect information concerning the portion of the annual premium for coverage for the employee or related individual under the plan.

(4) Wellness program incentives.[59] Nondiscriminatory wellness program incentives offered by an eligible employer-sponsored plan that affect premiums are treated as earned in determining an employee's required contribution for purposes of affordability of an eligible employer-sponsored plan to the extent the incentives relate exclusively to tobacco use. Wellness program incentives that do not relate to tobacco use or that include a component unrelated to tobacco use are treated as not earned for this purpose. For purposes of this subsection, the term "wellness program incentive" has the same meaning as the term "reward" in 26 CFR § 54.9802-1(f)(1)(i).

(5) Employer contributions to health reimbursement arrangements.[60] Amounts newly made available for the current plan year under a health reimbursement arrangement that an employee may use to pay premiums, or may use to pay cost-sharing or benefits not covered by the primary plan in addition to premiums, reduce the employee's required contribution if the health reimbursement arrangement would be integrated, as that term is used in IRS Notice 2013-54 (2013-40 IRB 287), with an eligible employer-sponsored plan for an employee enrolled in the plan. The eligible employer-sponsored plan and the health reimbursement arrangement must be offered by the same employer. Employer contributions to a health reimbursement arrangement reduce an employee's required contribution only to the extent the amount of the annual contribution is required under the terms of the plan or otherwise determinable within a reasonable time before the employee must decide whether to enroll in the eligible employer-sponsored plan.

(6) Employer contributions to cafeteria plans.[61] Amounts made available for the current plan year under a cafeteria plan, within the meaning of 26 USC § 125, reduce an employee's or a related individual's required contribution if:

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

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

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

(7) [Reserved]

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

[59] 26 CFR § 1.36B-2(c)(3)(v)(A)(4).

[60] 26 CFR § 1.36B-2(c)(3)(v)(A)(5).

[61] 26 CFR § 1.36B-2(c)(3)(v)(A)(6).

subsection.

(b) Affordability for part-year period.[62] Affordability under paragraph (a)(1) of this subsection is determined separately for each employment period that is less than a full calendar year or for the portions of an employer's plan year that fall in different benefit years of an applicable tax filer (a part-year period). Coverage under an eligible employer-sponsored plan is affordable for a part-year period if the annualized required contribution for self-only coverage, in the case of an employee, or family coverage, in the case of a related individual, under the plan for the part-year period does not exceed the required contribution percentage of the applicable tax filer's household income for the benefit year. The employee's annualized required contribution is the employee's required contribution for the part-year period times a fraction, the numerator of which is 12 and the denominator of which is the number of months in the part-year period during the applicable tax filer's benefit year. Only full calendar months are included in the computation under this paragraph.

(c) Required contribution percentage.[63] The required contribution percentage for 2014 is 9.5 percent. For plan years beginning in a calendar year after 2014, the percentage will be adjusted by the ratio of premium growth to income growth for the preceding calendar year and may be further adjusted to reflect changes to the data used to compute the ratio of premium growth to income growth for the 2014 calendar year or the data sources used to compute the ratio of premium growth to income growth. Premium growth and income growth will be determined under IRS-published guidance. In addition, the percentage may be adjusted for plan years beginning in a calendar year after 2018 to reflect rates of premium growth relative to growth in the consumer price index.

(d) Examples.[64] For examples illustrating these provisions, see 26 CFR § 1.36B-2(c)(3)(v)(D).

23.03 Minimum value for employer-sponsored MEC[65] (01/15/2017, GCR 16-096)

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

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

(a) In general.[66] Except as provided in paragraph (b) of this subsection, the requirements of affordability and

[62] 26 CFR § 1.36B-2(c)(3)(v)(B).

[63] 26 CFR § 1.36B-2(c)(3)(v)(C). For plan years after 2014, the required contribution percentage will be updated in accordance with IRS-published guidance, available at www.irs.gov. For example, the required contribution percentage for 2016 is located at: https://www.irs.gov/pub/irs-drop/rp-14-62.pdf.

[64] 26 CFR § 1.36B-2(c)(3)(v)(D).

[65] 45 CFR § 156.145; see, also, 26 CFR §§ 1.36B-2(c)(3)(vi) and 1.36B-6.

[66] 26 CFR § 1.36B-2(c)(3)(vii)(A).

minimum value do not apply for months that an individual is enrolled in an eligible employer-sponsored plan.

(b) Automatic enrollment.[67] An employee or related individual is treated as not enrolled in an eligible employer-sponsored plan for a month in a plan year or other period for which the employee or related individual is automatically enrolled if the employee or related individual terminates the coverage before the later of the first day of the second full calendar month of that plan year or other period or the last day of any permissible opt-out period provided by the employer-sponsored plan or in regulations to be issued by the Department of Labor, for that plan year or other period.

(c) Examples.[68] The following examples illustrate the provisions of this subsection:

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

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

(3) Example 3. The facts are the same as in Example 1, except that Employer X automatically enrolls H in the plan for calendar year 2015. H terminates the coverage on January 20, 2015. Under paragraph (b) of this subsection, H is not eligible for MEC under X's plan for January 2015.

23.05 Special eligibility rules[69] (01/01/2018, GCR 17-045)

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

(b) VHC unable to discontinue APTC

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

[67] 26 CFR § 1.36B-2(c)(3)(vii)(B).

[68] 26 CFR § 1.36B-2(c)(3)(vii)(C).

[69] 26 CFR § 1.36B-2(c)(4).

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

23.06 Eligibility determinations for MEC exemptions[70] (01/01/2018, GCR 17-045)

(a) In general.[71] AHS will satisfy the requirement to determine eligibility for an exemption from the shared responsibility payment by adopting an exemption eligibility determination made by HHS.

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

[71] 45 CFR § 155.625. Exemption applications and instructions are located at www.healthcare.gov/health-coverage-exemptions.

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
	The Valley News (advertising@vnews.com)	Tel: 603-298-8711 FAX: 603-298-0212
	The Addison Independent (legals@addisonindependent.com)	Tel: 388-4944 FAX: 388-3100 Attn: Display Advertising
	The Bennington Banner / Brattleboro Reformer Lylah Wright (lwright@reformer.com)	Tel: 254-2311 ext. 132 FAX: 447-2028 Attn: Lylah Wright
	The Chronicle (ads@bartonchronicle.com)	Tel: 525-3531 FAX: 525-3200
	Herald of Randolph (ads@ourherald.com)	Tel: 728-3232 FAX: 728-9275 Attn: Brandi Comette
	Newport Daily Express (jlafoe@newportvermontdailyexpress.com)	Tel: 334-6568 FAX: 334-6891 Attn: Jon Lafoe
	News & Citizen (mike@stowereporter.com)	Tel: 888-2212 FAX: 888-2173
	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, Nonfinancial Eligibility Requirements (Part 3).

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: 26P022
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