HHC - federally supported state-based exchange language (with Donahue amendments

Sec. X. VERMONT HEALTH CONNECT ~~**MILESTONES**~~ **OUTCOMES**; JOINT FISCAL COMMITTEE

(a) The Joint Fiscal Committee and the Health Reform Oversight Committee shall receive testimony from the Chief of Health Care Reform regarding the Vermont Health Benefit Exchange at their November meetings or at special meetings in November called by the respective Committee Chairs. The Chief of Health Care Reform shall report on the **intended** Vermont Health Connect ~~**milestones**~~ **outcomes** established in subsection (b) of this section and shall recommend whether the State should request approval from the U.S. Department of Health and Human Services to move from a State-based health benefit exchange to a federally supported State-based marketplace (FSSBM). **The Chief's recommendation shall be based on the Vermont Health Connect's success in achieving the intended outcomes identified in subsection (b) of this section, as well as whether the transition to an FSSBM would be likely to minimize any negative effects on individuals and families enrolling in qualified health plans, the financial impacts of the transition, the ability of the registered carriers to accomplish the transition, and the potential impacts of the transition on the State's health insurance regulatory framework.**

(b) The Chief shall report to the Committees on the following ~~**milestones**~~ **intended outcomes** for Vermont Health Connect processes relating to qualified health plans offered in the individual market:

(1) On or before May 31, 2015, the vendor under contract with the State to implement the Vermont Health Benefit Exchange shall deliver the information technology release providing the "back end" of the technology supporting changes in circumstances and changes in information to allow for a significant reduction, as described in subdivision (5) of this subsection, in the amount of time necessary for the State to process changes requested by individual and families enrolled in qualified health plans.

(2) On or before May 31, 2015, the State shall enter into a contract for renewal of qualified health plans offered to individuals and families that has been reviewed and agreed to by the State, by registered carriers offering qualified health plans, and by the chosen vendor. The contract shall be sent to the Centers for Medicare and Medicaid Services for its review by the same date.

(3) On or before August 1, 2015, the Vermont Health Connect shall develop a contingency plan for renewing qualified health plans offered to individuals and families for calendar year 2016 and shall ensure that the registered carriers offering these qualified health plans agree to the process.

(4) On or before October 1, 2015, the vendor under contract with the State for renewal of qualified health plans offered to individuals and families

shall deliver the information technology release providing for the renewal of those qualified health plans.

(5) On or before October 1, 2015, Vermont Health Connect customer service representatives shall begin processing new requests for changes in circumstances and for changes in information received in the first half of a month in time to be reflected on the next invoice and shall begin processing requests for changes received in the latter half of the month in time to be reflected on one of the next two invoices.

(6) On or before October 1, 2015, registered carriers that offer qualified health plans and wish to enroll individuals and families directly shall have completed implementation of any necessary information technology upgrades.

(c) The Chief shall provide the Committees with additional information regarding the potential transition to an FSSBM, including:

(1) the outcome of King v. Burwell, Docket No. 14-114 (U.S. Supreme Court), relating to whether federal advance premium tax credits will be available to reduce the cost of health insurance provided through a federally facilitated exchange, and the likely impacts on Vermont individuals and families if the State moves to an FSSBM;

(2) whether it is feasible to offer State premium and cost-sharing assistance to individuals and families purchasing qualified health plans through an FSSBM, how such assistance could be implemented, whether federal financial participation would be available through the Medicaid program, and applicable cost implications;

(3) how the Department of Financial Regulation's and Green Mountain Care Board's regulatory authority over health insurers and qualified health plans would be affected, including the timing of health insurance rate and form review;

(4) any impacts on the State's other health care reform efforts, including the Blueprint for Health and payment reform initiatives; ~~**and**~~

(5) any available estimates of the costs attributable to a transition from a State-based exchange to an FSSBM**; and**

(6) whether any new developments have occurred that affect the availability of additional alternatives that would be more beneficial to Vermonters by minimizing negative effects on individuals and families enrolling in qualified health plans, reducing the financial impacts of the transition to an alternative model, lessening the administrative burden of the transition on the registered carriers, and decreasing the potential impacts on the State's health insurance regulatory framework.

(d)(1) On or before December 1, 2015, the Joint Fiscal Committee shall determine whether to concur with the recommendation of the Chief of Health Care Reform regarding a request for approval from the U.S. Department of Health and Human Services to transition from a State-based health benefit exchange to an FSSBM. In determining whether to concur, the Joint Fiscal Committee shall consider whether the transition to an FSSBM would be likely to minimize any negative effects on individuals and families enrolling in qualified health plans, the financial impacts of the transition, the ability of the

registered carriers to accomplish the transition, and the potential impacts of the transition on the State's health insurance regulatory framework.

(2) If the Chief of Health Care Reform recommends requesting approval from the U.S. Department of Health and Human Services to allow Vermont to transition from a State-based exchange to an FSSBM and the Joint Fiscal Committee concurs with that recommendation, the Chief of Health Care Reform and the Commissioner of Vermont Health Access shall:

(A) prior to December 31, 2015, request that the U.S. Department of Health and Human Services begin the approval process with the Department of Vermont Health Access; and

(B) on or before January 15, 2016, provide to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance the recommended statutory changes necessary to align with operating an FSSBM if approved by the U.S. Department of Health and Human Services.

(3) If the intended outcomes described in subsection (b) of this section are not met and the Chief of Health Care Reform either does not recommend that Vermont transition to an FSSBM or the Joint Fiscal Committee does not concur with the Chief's recommendation to transition to an FSSBM, the Chief of Health Care Reform or designee shall evaluate other available models and options for Vermont's health benefit exchange and shall submit information to the House Committee on Health Care and the Senate Committees on Health and Welfare and on Finance on or before January 15, 2016 regarding the advantages and disadvantages of

each of the models and options and the proposed statutory changes that would be necessary to accomplish them.