**Revised FSSBM language with triggers**

Sec. 22. VERMONT HEALTH CONNECT OUTCOMES; JOINT FISCAL COMMITTEE

(a)(1) If the vendor under contract with the State to implement the Vermont Health Benefit Exchange fails to deliver the information technology release providing the "back end" of the technology supporting changes in circumstances and changes in information by June 15, 2015, the Chief of Health Care Reform shall explore with the U.S. Department of Health and Human Services a transition to a federally supported, State-based marketplace (FSSBM).

(2) If the State fails to complete a contract to ensure renewal functionality for 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, and send the contract to the Centers for Medicare and Medicaid Services for its review, by June 15, 2015, the Chief of Health Care Reform shall explore with the U.S. Department of Health and Human Services a transition to an FSSBM.

(3) If the information technology release supporting changes in circumstances and changes in information is not delivered or the State fails to complete the contract for renewal functionality by June 15, 2015, 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 next scheduled meetings or at special meetings

called by the respective Committee Chairs prior to September 1, 2015. The Chief of Health Care Reform shall report on progress toward achieving additional Vermont Health Connect outcomes and shall recommend whether the State should formally request approval from the U.S. Department of Health and Human Services to move from a State-based health benefit exchange to an FSSBM. The Chief's recommendation shall be based on Vermont Health Connect's success in achieving intended outcomes, the information provided pursuant to subsection (d) of this section, and a determination of 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)(1) If the information technology release supporting changes in circumstances and changes in information is delivered by June 15, 2015 and the State completes the contract for renewal functionality by the same date but Vermont Health Connect fails to develop a contingency plan for renewing qualified health plans offered to individuals and families for calendar year 2016 that is agreed to by the registered carriers by August 15, 2015, the Chief of Health Care Reform shall explore with the U.S. Department of Health and Human Services a transition to an FSSBM.

(2) If a contingency plan for renewing qualified health plans offered to individuals and families for calendar year 2016 has not been developed and

agreed to by the registered carriers by August 15, 2015, 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 next scheduled meetings or at special meetings called by the respective Committee Chairs prior to October 1, 2015. The Chief of Health Care Reform shall report on progress toward achieving additional Vermont Health Connect outcomes and shall recommend whether the State should formally request approval from the U.S. Department of Health and Human Services to move from a State-based health benefit exchange to an FSSBM. The Chief's recommendation shall be based on Vermont Health Connect's success in achieving intended outcomes, the information provided pursuant to subsection (d) of this section, and a determination of 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.

(c)(1) If a contingency plan for renewing qualified health plans in 2016 has been developed and agreed to by the registered carriers by August 15, 2015 but the vendor under contract with the State for renewal of qualified health plans offered to individuals and families fails to deliver the information technology release providing for the renewal of those plans by October 15, 2015, the Chief

of Health Care Reform shall explore with the U.S. Department of Health and Human Services a transition to an FSSBM.

(2) If a contingency plan for renewing qualified health plans in 2016 has been developed and agreed to by the registered carriers by August 15, 2015 but Vermont Health Connect customer service representatives are unable by October 15, 2015 to 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 processing requests for changes received in the latter half of the month in time to be reflected on one of the next two invoices, the Chief of Health Care Reform shall explore with the U.S. Department of Health and Human Services a transition to an FSSBM.

(3) If a contingency plan for renewing qualified health plans in 2016 has been developed and agreed to by the registered carriers by August 15, 2015 but the registered carriers electing to enroll individuals and families directly in qualified health plans have not completed implementation of any necessary information technology upgrades by October 15, 2015, the Chief of Health Care Reform shall explore with the U.S. Department of Health and Human Services a transition to an FSSBM.

(3) If, by October 15, 2015, the vendor has failed to deliver the information technology release providing for the renewal of qualified plans, customer service representatives are unable to begin processing new requests for changes in circumstances and for changes in information in a timely manner, or the registered carriers have not completed implementation of

necessary information technology upgrades for direct enrollment, 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 progress toward achieving additional Vermont Health Connect outcomes and shall recommend whether the State should formally request approval from the U.S. Department of Health and Human Services to move from a State-based health benefit exchange to an FSSBM. The Chief's recommendation shall be based on Vermont Health Connect's success in achieving intended outcomes, the information provided pursuant to subsection (d) of this section, and a determination of 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.

(d) If, based on the outcome of the events described in subsections (a)–(c) of this section, the Chief of Health Care Reform testifies at a September or November meeting of the Joint Fiscal Committee and of the Health Reform Oversight Committee about a potential transition to an FSSBM, the Chief shall provide the Committees with the following information regarding such a transition:

(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;

(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.

(e)(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 subsections (a)–(c) 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.