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SENATE BILL NO. 45

AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by the Senate Committee on Commerce and Labor on February 3, 2014)

(Patron Prior to Substitute—Senator Watkins)

A BILL to amend and reenact §§ 38.2-4214, 38.2-4319, and 38.2-4509 of the Code of Virginia and to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6415, and to repeal the second enactment of Chapter 679 of the Acts of Assembly of 2013, relating to the establishment and operation of Marketplace Virginia to facilitate the purchase and sale of health plans and dental plans in the Commonwealth; assessments.

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214, 38.2-4319, and 38.2-4509 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6415, as follows:

§ 38.2-4214. Application of certain provisions of law.

No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-230, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-700 through 38.2-705, 38.2-900 through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, 38.2-1317 through 38.2-1328, 38.2-1334, 38.2-1340, 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3400, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3406.2, 38.2-3407.1 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.18, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3501, 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, §§ 38.2-3516 through 38.2-3520 as they apply to Medicare supplement policies, §§ 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3541 through 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), §§ 38.2-3600 through 38.2-3607, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.) ~~of this title~~, *and Chapter 64 (§ 38.2-6400 et seq.)* shall apply to the operation of a plan.

§ 38.2-4319. Statutory construction and relationship to other laws.

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.18, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.1, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.), *and Chapter 64 (§ 38.2-6400 et seq.)* shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

B. For plans administered by the Department of Medical Assistance Services that provide benefits pursuant to Title XIX or Title XXI of the Social Security Act, as amended, no provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-322, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.) and 5 (§ 38.2-1322 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6,

38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.)*, and Chapter 64 (§ 38.2-6400 et seq.)* shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

C. Solicitation of enrollees by a licensed health maintenance organization or by its representatives shall not be construed to violate any provisions of law relating to solicitation or advertising by health professionals.

D. A licensed health maintenance organization shall not be deemed to be engaged in the unlawful practice of medicine. All health care providers associated with a health maintenance organization shall be subject to all provisions of law.

E. Notwithstanding the definition of an eligible employee as set forth in § 38.2-3431, a health maintenance organization providing health care plans pursuant to § 38.2-3431 shall not be required to offer coverage to or accept applications from an employee who does not reside within the health maintenance organization's service area.

F. For purposes of applying this section, "insurer" when used in a section cited in subsections A and B shall be construed to mean and include "health maintenance organizations" unless the section cited clearly applies to health maintenance organizations without such construction.

§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, Article 4 (§ 38.2-1317 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.1, 38.2-3407.4, 38.2-3407.10, 38.2-3407.13, 38.2-3407.14, 38.2-3407.15, 38.2-3407.17, 38.2-3415, 38.2-3541, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.)*, and Chapter 64 (§ 38.2-6400 et seq.)* shall apply to the operation of a plan.

B. The provisions of subsection A of § 38.2-322 shall apply to an optometric services plan. The provisions of subsection C of § 38.2-322 shall apply to a dental services plan.

C. The provisions of Article 1.2 (§ 32.1-137.7 et seq.) of Chapter 5 of Title 32.1 shall not apply to either an optometric or dental services plan.

D. The provisions of § 38.2-3407.1 shall apply to claim payments made on or after January 1, 2014. No optometric or dental services plan shall be required to pay interest computed under § 38.2-3407.1 if the total interest is less than $5.

CHAPTER 64.

MARKETPLACE VIRGINIA.

§ 38.2-6400. Definitions.

As used in this chapter, unless the context requires a different meaning:

"American Health Benefit Marketplace" means the program established as a component of the Marketplace pursuant to this chapter that is designed to facilitate the purchase of qualified health plans or qualified dental plans by qualified individuals.

"Bureau" means the Bureau of Insurance, an administrative division within the Commission.

"Committee" means the Advisory Committee appointed by the Commission pursuant to § 38.2-6403.

"Director" means the Director of the Division appointed by the Commission pursuant to § 38.2-6402.

"Division" means the Marketplace Virginia Division, an administrative division of the Commission.

"Eligible employee" means an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP marketplace.

"Eligible entity" means the Bureau, the Department of Medical Assistance Services, or an entity that has demonstrated experience on a statewide or regional basis in individual and small group health insurance markets and in benefits coverage; however, a health carrier or an affiliate of a health carrier is not an eligible entity.

"Essential health benefits benchmark plan" means the standardized set of essential health benefits that must be met by a qualified health plan or qualified dental plan, as defined in 45 C.F.R. § 155.20, or other health insurance issuer as required by 45 C.F.R. § 147.150.

"Essential health benefits package" means the scope of covered benefits and associated limits of a

health benefit plan that (i) provides at least the 10 statutory categories of benefits, as described in 45 C.F.R. § 156.110(a); (ii) provides the benefits in the manner described in 45 C.F.R. § 156.115; (iii) limits cost-sharing for such coverage as described in 45 C.F.R. § 156.130; and (iv) subject to offering catastrophic plans as described in § 1302(e) of the Federal Act, provides distinct levels of coverage as described in 45 C.F.R. § 156.140.

"FAMIS" means the Family Access to Medical Insurance Security Plan, including the FAMIS Plus program, established pursuant to Chapter 13 (§ 32.1-351 et seq.) of Title 32.1.

"Federal Act" means the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, and regulations issued thereunder.

"Health benefit plan" or "plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. The term does not include coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for onsite medical clinics; or other similar insurance coverage, specified in federal regulations issued pursuant to the Federal Act, under which benefits for medical care are secondary or incidental to other insurance benefits. The term does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar limited benefits specified in federal regulations issued pursuant to the Federal Act. The term does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness, for hospital indemnity, or other fixed indemnity insurance. The term does not include the following if offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under § 1882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services); or similar supplemental coverage provided to coverage under a group health plan.

"Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of the Commonwealth and subject to the jurisdiction of the Commission that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including an insurer licensed to sell accident and sickness insurance, a health maintenance organization, a nonprofit hospital and health service corporation, a dental plan organization, a dental services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Marketplace" means, as the context requires, either (i) the Division or (ii) Marketplace Virginia established pursuant to the provisions of this chapter and in accordance with 1311(b) of the Federal Act, through which qualified health plans and qualified dental plans are made available to qualified individuals through the American Health Benefit Marketplace and to qualified employers through the SHOP marketplace. "Marketplace," when referring to Marketplace Virginia, collectively refers to both the American Health Benefit Marketplace and the SHOP marketplace.

"Navigator" means a public or private entity or individual that is qualified, and licensed if appropriate, to engage in the activities and meet the standards described in 45 C.F.R. § 155.210.

"PHSA" means the federal Public Health Service Act, Chapter 6A of Title 42 of the United States Code, as amended.

"Qualified dental plan" means a limited scope dental plan that has been certified in accordance with § 38.2-6406.

"Qualified employer" means a small employer that elects to make all of its full-time employees eligible for one or more qualified health plans or qualified dental plans in the small group market offered through the SHOP marketplace and, at the employer's option, some or all of its part-time employees, provided that the employer (i) has its principal place of business in the Commonwealth and elects to provide coverage through the SHOP marketplace to all of its eligible employees, wherever employed, or (ii) elects to provide coverage through the SHOP marketplace to all of its eligible employees who are principally employed in the Commonwealth.

"Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in § 1311(c) of the Federal Act and § 38.2-6406.

"Qualified individual" means an individual, including a minor, who (i) is seeking to enroll in a

qualified health plan or qualified dental plan offered to individuals through the Marketplace; (ii) resides in the Commonwealth; (iii) is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges; and (iv) is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or a national of the United States or an alien lawfully present in the United States.

"Secretary" means the Secretary of the federal Department of Health and Human Services.

"SHOP marketplace" means the Small Business Health Options Program, established as a component of the Marketplace pursuant to this chapter, through which a qualified employer can provide its eligible employees and their dependents with access to one or more qualified health plans or qualified dental plans.

"Small employer" means an employer that employed an average of (i) until January 1, 2016, at least one but not more than 50 employees during the preceding calendar year or (ii) commencing January 1, 2016, up to 100 employees during the preceding calendar year. For the purposes of this definition: (a) all persons treated as a single employer under subsection (b), (c), (m), or (o) of 26 U.S.C. § 414 shall be treated as a single employer; (b) an employer and any predecessor employer shall be treated as a single employer; and (c) all employees shall be counted, including part-time employees and employees who are not eligible for health insurance coverage through the employer. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees reasonably expected to be employed by the employer on business days in the current calendar year. An employer that makes enrollment in qualified health plans or qualified dental plans available to its eligible employees through the SHOP marketplace and that no longer meets the definition of a small employer because of an increase in the number of its employees shall continue to be treated as a small employer for purposes of this chapter as long as that employer continuously makes enrollment through the SHOP marketplace available to its eligible employees.

"Small group market" means the health insurance market under which individuals obtain health insurance coverage, directly or through any arrangement, on behalf of themselves and their dependents through a group health plan maintained by a small employer.

"State-mandated health benefit" means coverage required under this title or other laws of the Commonwealth to be provided in a policy of accident and sickness insurance, an accident and sickness subscription contract, or a health maintenance organization health care plan that includes coverage for specific health care services or benefits.

"State Medicaid Program" means the Commonwealth's Medicaid program under Title XIX of the Social Security Act, as amended from time to time.

§ 38.2-6401. Purpose.

The purpose of this chapter is to provide for the establishment of Marketplace Virginia, in order to make qualified health plans and qualified dental plans available to qualified individuals in the Commonwealth and to provide for the establishment of a Small Business Health Options Program to assist qualified small employers in the Commonwealth in facilitating the enrollment of their eligible employees in qualified health plans and qualified dental plans offered in the small group market. The intent of the Marketplace is to reduce the number of uninsured, promote a transparent and competitive marketplace, promote consumer choice and education, and assist individuals with access to programs, premium assistance tax credits, and cost-sharing reductions.

§ 38.2-6402. Division established; Marketplace created.

A. The Commission shall establish the Marketplace Virginia Division as a separate division within the Commission. Marketplace Virginia shall be established and administered by the Commission, through the Division, in compliance with the requirements of this chapter and the Federal Act. The Marketplace shall facilitate the purchase and sale of qualified health plans and qualified dental plans to qualified individuals and qualified employers.

B. The Commission shall appoint a Director of the Division, who shall have overall management responsibility for the Marketplace.

C. The Commission, through the Division, shall have governing power and authority in any matter pertaining to the Marketplace. The Commission may delegate as it may deem proper such powers and duties to the Director.

D. The Commission shall carry out its duties and responsibilities under this chapter in accordance with its rules of practice and procedure and shall decide all matters related to the Marketplace in the same manner as it does when performing its other regulatory, judicial, and administrative duties and responsibilities under this Code.

E. Notwithstanding any provision of subsection A to the contrary, the Virginia Secretary of Health and Human Resources shall be responsible for (i) providing technology infrastructure development and implementation thereof; (ii) providing ongoing technology support services and maintenance of core information systems platforms, including website development and maintenance; (iii) managing the

procurement of technology hardware, software, and technology services, other than personal computers, laptops, and other equipment used by the Marketplace to carry out its functions; and (iv) providing the Commission with secured access to the system functions for eligibility and enrollment, plan administration, customer service, financial management, and marketing, outreach and education. The Virginia Secretary of Health and Human Resources shall bill the Commission for access to such systems based on fair and reasonable billing rates.

§ 38.2-6403. Advisory Committee.

A. The Commission shall create an Advisory Committee to advise and provide recommendations to the Commission and the Director in carrying out the purposes and duties of the Marketplace. The Committee shall consist of seven to nine members appointed by the Commission. The term of office for each member appointed by the Commission shall be four years. A member appointed by the Commission is eligible for no more than two full terms. In appointing the members of the Committee, the Commission shall appoint one member in good standing of the American Academy of Actuaries with experience in health insurance markets, one economist with experience in the health care markets, one consumer representative, one health consumer advocate, one representative of small employers, one physician, and one representative of a participating qualified health plan.

B. The Commissioner of Insurance, the Director of the Department of Medical Assistance Services, the Commissioner of the Department of Social Services, and the Virginia Secretary of Health and Human Resources shall serve as ex officio nonvoting members of the Committee. An ex officio member may designate a representative to serve in his place.

C. No member of the Committee shall be a legislator or hold any elective office in state government.

D. All meetings of the Committee shall be announced at least one week in advance on the Marketplace website and shall be open to the public. The Committee shall permit reasonable public comment concerning matters on a meeting's agenda at meetings not less frequently than quarterly. The Committee shall announce prior to its meetings whether public comment will be accepted. The Committee shall accept written comment from the public on an ongoing basis.

E. A majority of the members appointed by the Commission shall constitute a quorum. No proposed recommendation shall be adopted by the Committee unless approved by a majority of members appointed by the Commission who are present.

F. The Director shall ensure that the Committee is provided promptly with reasons for any decision by him or by the Commission not to accept recommendations of the Committee.

G. Minutes of meetings of the Committee, which shall include the Committee's recommendations and any responses to its recommendations, shall be available to the public and posted on the Marketplace 's website.

§ 38.2-6404. Marketplace requirements.

A. The Marketplace shall make qualified health plans and qualified dental plans available to qualified individuals and qualified employers beginning on a date set by the Commission, which date shall not be later than July 1, 2016, unless the Commission determines that postponement of such date is necessary to complete the establishment of the Marketplace. The Marketplace shall not make available any health benefit plan that is not a qualified health plan. The Marketplace shall allow a health carrier to offer a qualified dental plan separately.

B. The Marketplace shall provide for the establishment of a SHOP marketplace to assist qualified small employers in the Commonwealth in facilitating the enrollment of their eligible employees in a qualified health plan or plans or a qualified dental plan or plans.

C. The Marketplace shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of § 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Marketplace, if the plan provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J) of the Federal Act.

D. Neither the Marketplace nor a carrier offering health benefit plans through the Marketplace may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of § 36B(c)(2)(C) of the Internal Revenue Code of 1986.

§ 38.2-6405. Duties of Marketplace.

The Marketplace shall:

1. Implement procedures for the certification, recertification, and decertification of qualified health plans and qualified dental plans consistent with guidelines developed by the Secretary under § 1311(c) of the Federal Act and § 38.2-6406;

2. Provide for enrollment periods, as provided under § 1311(c)(6) of the Federal Act;

3. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

4. Utilize an Internet website developed and maintained by the Virginia Secretary of Health and

Human Resources on which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans, including, at a minimum, (i) premium and cost-sharing information; (ii) the summary of benefits and coverage offered; (iii) identification of a qualified health plan as a bronze-, silver-, gold-, or platinum-level plan as defined by § 1302(d) of the Federal Act or a catastrophic plan as defined by § 1302(e) of the Federal Act; (iv) the results of enrollee satisfaction surveys, described in § 1311(c)(4) of the Federal Act; (v) quality ratings assigned pursuant to § 1311(c)(3) of the Federal Act; (vi) medical loss ratio information as reported to the Secretary in accordance with 45 C.F.R. Part 158; (vii) transparency of coverage measures reported to the Marketplace during certification processes; and (viii) the provider directory made available to the Marketplace. The website shall be accessible to persons with disabilities, shall provide meaningful access for persons with limited English proficiency, and shall contain the information described in clauses (i) through (viii) without diversion to a website of a carrier;

5. Assign a rating to each qualified health plan offered through the Marketplace in accordance with the criteria developed by the Secretary under § 1311(c)(3) of the Federal Act;

6. Determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under § 1302(d)(2)(A) of the Federal Act;

7. Use a standardized format for presenting health benefit options in the Marketplace, including the use of the uniform outline of coverage as established under § 2715 of the PHSA, 42 U.S.C. § 300gg-15;

8. Inform individuals, in accordance with § 1413 of the Federal Act, of eligibility requirements for (i) the State Medicaid Program, (ii) the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, including FAMIS, as amended from time to time, or (iii) any applicable state or local public health subsidy program, and enroll an individual in such program if it is determined, through screening of the application, that such individual is eligible for any such program;

9. Make available by electronic means through the website described in subdivision 4 a calculator to determine the actual cost of coverage after application of any premium assistance tax credit under 26 U.S.C. § 36B and any cost-sharing reduction under § 1402 of the Federal Act;

10. Establish an American Health Benefit Marketplace through which qualified individuals may enroll in any qualified health plan or qualified dental plan offered through the American Health Benefit Marketplace for which they are eligible, and establish a SHOP marketplace through which qualified employers may make their eligible employees eligible for one or more qualified health plans or qualified dental plans offered through the SHOP marketplace or specify a level of coverage so that any of their eligible employees may enroll in any qualified health plan or qualified dental plan offered through the SHOP marketplace at the specified level of coverage;

11. Subject to § 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under § 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because there is no affordable qualified health plan available through the Marketplace, or the individual's employer, covering the individual or the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

12. Transfer to the U.S. Secretary of the Treasury the following:

a. A list of the individuals who are issued a certification under subdivision 11, including the name and taxpayer identification number of each individual;

b. The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium assistance tax credit under 26 U.S.C. § 36B because (i) the employer did not provide minimum essential coverage or (ii) the employer provided minimum essential coverage but a determination under 26 U.S.C. § 36B(c)(2)(C) found that either the coverage was unaffordable for the employee or did not provide the required minimum actuarial value; and

c. The name and taxpayer identification number of (i) each individual who notifies the Marketplace under 42 U.S.C. 18081 that the individual has changed employers and (ii) each individual who ceases coverage under a qualified health plan or qualified dental plan during the plan year and the effective date of the cessation;

13. Provide to each employer the name of each of the employer's employees described in subdivision 12 b who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

14. Perform duties required of the Marketplace by the Secretary or the U.S. Secretary of the Treasury related to determining eligibility for premium assistance tax credits, reduced cost-sharing, or individual responsibility requirement exemptions;

15. Certify entities qualified to serve as Navigators in accordance with § 1311(i) of the Federal Act and § 38.2-6413;

16. Review the rate of premium growth within the Marketplace and outside the Marketplace and consider the information in developing recommendations on whether to continue limiting qualified

employer status to small employers;

17. Consult with stakeholders relevant to carrying out the activities required under this chapter, including, but not limited to:

a. Educated health care consumers who are enrollees in qualified health plans and qualified dental plans;

b. Individuals and entities with experience in facilitating enrollment in qualified health plans and qualified dental plans;

c. Advocates for enrolling hard-to-reach populations, which include individuals with mental health or substance abuse disorders;

d. Representatives of small businesses and self-employed individuals;

e. The Department of Medical Assistance Services;

f. Federally recognized tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994 (25 U.S.C. § 479a), that are located within the Marketplace's geographic area;

g. Public health experts;

h. Health care providers;

i. Large employers;

j. Health carriers; and

k. Insurance agents;

18. Meet the following financial integrity requirements:

a. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, and the Commission a report concerning such accountings;

b. Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:

(1) Investigate the affairs of the Marketplace;

(2) Examine the properties and records of the Marketplace; and

(3) Require periodic reports in relation to the activities undertaken by the Marketplace; and

c. Not use any funds in carrying out its activities under this chapter that are intended for the administrative and operational expenses of the Marketplace for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications; and

19. Take any other actions necessary and appropriate to ensure that the Marketplace complies with the requirements of the Federal Act.

§ 38.2-6406. Certification of health benefit plans as qualified health plans.

A. The Marketplace, in consultation with the Bureau, shall certify a health benefit plan as a qualified health plan, unless the Marketplace determines that making the plan available through the Marketplace is not in the interest of qualified individuals and qualified employers in the Commonwealth, if:

1. The plan provides the essential health benefits package, except that (i) the plan shall not provide any state-mandated health benefit that is not provided in the essential health benefits package and (ii) the plan is not required to provide benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection F, if (a) the Marketplace has determined that at least one qualified dental plan is available to supplement the plan's coverage and (b) the health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Bureau, that such plan does not provide the full range of pediatric dental benefits included in the essential health benefits package, and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the Marketplace;

2. The premium rates and contract language have been approved by or filed with the Commission, in accordance with §§ 38.2-316 and 38.2-316.1;

3. The plan provides at least a bronze level of coverage unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

4. The plan's cost-sharing requirements do not exceed the limits established under § 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP marketplace, the plan's deductible does not exceed the limits established under § 1302(c)(2) of the Federal Act;

5. The health carrier offering the plan:

a. Is licensed and in good standing to offer health insurance coverage in the Commonwealth;

b. Offers at least (i) one qualified health plan at a silver level of coverage and (ii) one qualified health plan at a gold level of coverage through each component of the Marketplace in which the health carrier participates, where "component" refers to the SHOP marketplace and the American Health Benefit Marketplace;

c. Charges the same premium rate for each qualified health plan without regard to whether the plan

is offered through the Marketplace or directly by the health carrier or through an agent;

d. Does not charge any cancellation fees or penalties in violation of subsection D of § 38.2-6404; and

e. Complies with the regulations developed by the Secretary under § 1311(d) of the Federal Act and such other requirements as the Marketplace may establish; and

6. The plan meets the requirements of certification as adopted by regulation pursuant to § 38.2-6414 or promulgated by the Secretary under § 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance.

B. The Marketplace shall not refuse to certify a health benefit plan as a qualified health plan (i) on the basis that the plan is a fee-for-service plan, (ii) through the imposition of premium price controls by the Marketplace, or (iii) on the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances that the Marketplace determines are inappropriate or too costly.

C. In order to foster a competitive marketplace and consumer choice, it is presumed to be in the interest of qualified individuals and qualified employers for the Marketplace to, and the Marketplace shall, certify all health benefit plans meeting the requirements of § 1311(c) of the Federal Act for participation in the Marketplace. The Marketplace shall establish and publish a transparent, objective process for decertifying qualified health plans if it is determined that it is not in the public interest to permit such plans to be offered through the Marketplace.

D. The Marketplace shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to:

1. Submit a justification for any premium increase to the Bureau before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Marketplace shall take this information, along with the information and the recommendations provided to the Marketplace by the Bureau under § 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Marketplace;

2. Make available to the public in plain language, as that term is defined in § 1311(e)(3)(B) of the Federal Act, and submit to the Marketplace, the Secretary, and the Bureau, accurate and timely disclosure of the following for such plan:

a. Claims payment policies and practices;

b. Periodic financial disclosures;

c. Data on enrollment;

d. Data on disenrollment;

e. Data on the number of claims that are denied;

f. Data on rating practices;

g. Information on cost-sharing and payments with respect to any out-of-network coverage;

h. Information on enrollee and participant rights under Title I of the Federal Act; and

i. Other information as determined appropriate by the Secretary; and

3. Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that such individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through the Marketplace's website and through other means for individuals without access to the Internet.

E. The Marketplace shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the Marketplace.

F. The provisions of this chapter that are applicable to qualified health plans shall also apply to the extent applicable to qualified dental plans, except as modified (i) by regulations adopted by the Commission or (ii) in accordance with the following:

1. A health carrier seeking certification of a dental benefit plan as a qualified dental plan shall be licensed in the Commonwealth to offer dental coverage, but need not be licensed to offer other health benefits;

2. Qualified dental plans shall be limited to dental and oral health benefits, without substantial duplication of the benefits typically offered by health benefit plans without dental coverage, and shall include, at a minimum, the pediatric dental benefits prescribed by the Secretary pursuant to § 1302(b)(1)(J) of the Federal Act and such other dental benefits as the Marketplace may specify or the Secretary may specify by regulation; and

3. Participants in the Marketplace shall have the option to purchase at least the pediatric dental benefit component of the essential health benefits package either through a separate qualified dental plan or as a part of a combined offer by a qualified health plan, provided that, with respect to a

combined offer, the health and dental benefits are priced separately and also made available for purchase separately at the same price.

§ 38.2-6407. Appeal of decertification or denial of certification.

A. The Marketplace shall give each health carrier the opportunity to appeal a decertification decision or the denial of certification as a qualified health plan or qualified dental plan.

B. The Marketplace shall give each health carrier that appeals a decertification decision or the denial of certification the opportunity for:

1. The submission and consideration of facts, arguments, or proposals of adjustment of the plan or plans at issue; and

2. A hearing and a decision on the record, to the extent that the Marketplace and the health carrier are unable to reach agreement following the submission of the information in subdivision 1.

C. Any hearing held pursuant to subsection B shall be conducted by the Commission in accordance with its rules of practice and procedure.

§ 38.2-6408. Open enrollment periods.

Health carriers shall be permitted to utilize open enrollment periods outside of the Marketplace as permitted inside of the Marketplace pursuant to § 1311(c)(6) of the Federal Act.

§ 38.2-6409. Choice; risk pooling.

A. In accordance with § 1312(f)(2)(A) of the Federal Act, a qualified employer may either designate one or more qualified health plans from which its eligible employees may choose or designate any level of coverage to be made available to eligible employees through a Marketplace.

B. In accordance with § 1312(b) of the Federal Act, a qualified individual enrolled in any qualified health plan may pay any applicable premium owed by such individual to the health carrier issuing such qualified health plan.

C. In accordance with § 1312(c) of the Federal Act:

1. A health carrier shall consider all enrollees in all health benefit plans, other than grandfathered health benefit plans, offered by such carrier in the individual market, including those enrollees who do not enroll in such plans through the American Health Benefit Marketplace, members of a single risk pool; and

2. A health carrier shall consider all enrollees in all health benefit plans, other than grandfathered health benefit plans, offered by such carrier in the small group market, including those enrollees who do not enroll in such plans through the SHOP marketplace, to be members of a single risk pool.

D. In accordance with § 1312(d) of the Federal Act:

1. This section shall not prohibit:

a. A health carrier from offering outside of the Marketplace a health benefit plan to a qualified individual or qualified employer; or

b. A qualified individual from enrolling in, or a qualified employer from selecting for its eligible employees, a health benefit plan offered outside of a Marketplace; and

2. This section shall not limit the operation of any requirement under state law or regulation with respect to any policy or plan that is offered outside of the Marketplace with respect to any requirement to offer benefits.

E. Nothing in this section shall restrict the choice of a qualified individual to enroll or not to enroll in a qualified health plan or to participate in a Marketplace.

F. Nothing in this section shall compel an individual to enroll in a qualified health plan or to participate in a Marketplace.

G. A qualified individual may enroll in any qualified health plan, except that in the case of a catastrophic plan described in § 1302(e) of the Federal Act, a qualified individual may enroll in the plan only if the individual is eligible to enroll in the plan under § 1302(e)(2) of the Federal Act.

H. In accordance with § 1312(e) of the Federal Act, the Marketplace may allow agents:

1. To enroll qualified individuals and qualified employers in any qualified health plan or any qualified dental plan offered through the Marketplace for which the individual or employer is eligible; and

2. To assist qualified individuals in applying for premium tax credits and cost-sharing reductions for qualified health plans purchased through the Marketplace.

§ 38.2-6410. Funding; publication of costs.

A. The Marketplace shall be authorized to fund its operations through (i) special fund revenues generated by assessment fees on all health carriers, including carriers offering plans through the Marketplace and outside the Marketplace, (ii) funds described in subsection I, or (iii) such funds as the General Assembly may from time to time appropriate.

B. The Marketplace shall have funding from the sources described in subsection A in an amount sufficient to support its ongoing operations beginning not later than the January 1 that follows the date the Marketplace begins making qualified health plans and qualified dental plans available to qualified

individuals and qualified employers.

C. Assessments on health carriers shall be reasonable and necessary to support the development, operations, and prudent cash management of the Marketplace. Assessments shall be approved by the Commission prior to implementation. Any assessment approved by the Commission shall vary among health carriers that offer plans through the Marketplace, health carriers only offering plans outside the Marketplace, and those that do both, in a manner that reasonably allocates the costs of the operations of the Marketplace among all such carriers based on the impact of their operations on the total costs of operating the Marketplace. Any assessments charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses that have been approved in the annual budget process, after consideration of other available funding. Services performed by the Marketplace on behalf of other state or federal programs shall not be funded with assessments or other fees collected from health carriers. Any unspent funding by the Marketplace shall be used for future state operation of the Marketplace or returned to health carriers as a credit if a state charges fees to carriers.

D. Taxes, fees, or assessments used to finance the Marketplace shall be clearly disclosed by the Marketplace as such.

E. Taxes, fees, or assessments used to finance the Marketplace shall be considered a state tax or assessment, as defined in § 2718(a) of the PHSA and its implementing regulations, and shall be excluded from health carrier administrative costs for the purpose of calculating medical loss ratios or rebates.

F. The Marketplace shall publish the average costs of licensing, regulatory fees, and any other payments required by the Marketplace, and the administrative costs of the Marketplace, on a Marketplace website in order to educate consumers on such costs. This information shall include information on monies lost to waste, fraud, and abuse.

G. Assessments and fees shall not affect the requirement under § 1301 of the Federal Act that carriers charge the same premium rate for each qualified health plan whether offered inside or outside the Marketplace.

H. A written report on the implementation and performance of the Marketplace functions during the preceding fiscal year, including, at a minimum, the manner in which funds were expended, shall be made available to the public on the website of the Marketplace.

I. The Marketplace is authorized to apply for and accept federal grants, other federal funds, and grants from nongovernmental organizations for the purposes of developing, implementing, and administering the Marketplace.

J. The Commission shall not use any special fund revenues dedicated to its other functions and duties, including, but not limited to, revenues from utility consumer taxes or fees from licensees regulated by the Commission, or fees paid to the Clerk's Office, to fund any of the activities or operating expenses of the Marketplace.

§ 38.2-6411. Procurement, contracting, and personnel.

A. The Commission may contract with other eligible entities and enter into memoranda of understanding with other agencies of the Commonwealth to carry out any of the functions of the Marketplace, including agreements with other states or federal agencies to perform joint administrative functions. Such contracts are not subject to the Virginia Public Procurement Act (§ 2.2-4300 et seq.).

B. The Marketplace shall not enter into contracts with any health carrier or an affiliate of a health carrier.

C. Employees of the Marketplace shall be (i) exempt from application of the Virginia Personnel Act (§ 2.2-2900 et seq.) and Chapter 30 (§ 2.2-3000 et seq.) of Title 2.2, as hereinafter amended or recodified, to the same extent as other employees of the Commission; (ii) eligible for participation in the Virginia Retirement System to the same extent as other similarly situated employees of the Commission; and (iii) compensated and managed in accordance with the Commission's practices and policies applicable to all Commission employees.

§ 38.2-6412. Confidentiality.

A. Notwithstanding any other provision of law, the records of the Marketplace shall be open to public inspection, except that the following information shall not be subject to disclosure: (i) the names and applications of individuals and employers seeking coverage through the Marketplace, (ii) individuals' health information, (iii) information exchanged between the Marketplace and any other state agency that is subject to confidentiality agreements under contracts entered into with the Marketplace, and (iv) communications covered by an applicable legal or other privilege or such internal communications related to the Marketplace that are designated confidential in regulations promulgated by the Commission to implement the provisions of this chapter.

B. The Marketplace may enter into information-sharing agreements with federal and state agencies and other states' health benefit exchanges to carry out its responsibilities under this chapter, provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

§ 38.2-6413. Navigators.

A. A public or private entity or individual shall not act as a Navigator unless the Marketplace has certified that the entity or individual is qualified to do so. The Marketplace shall certify entities to act as Navigators in accordance with § 1311(i) of the Federal Act, standards developed by the Secretary, and the requirements of this section.

B. The Marketplace shall not certify a public or private entity or an individual as qualified to serve as a Navigator unless the entity or individual meets the requirements of 45 C.F.R. § 155.210.

C. The Marketplace shall establish a program under which it shall award grants to Navigators to carry out the following duties:

1. Conduct public education activities to raise awareness of the availability of qualified health plans, qualified dental plans, the State Medicaid Program, and FAMIS;

2. Distribute fair and impartial information concerning enrollment in qualified health plans, qualified dental plans, the State Medicaid Program, and FAMIS, and the availability of premium tax credits under § 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under § 1402 of the Federal Act;

3. Facilitate enrollment in qualified health plans, qualified dental plans, the State Medicaid Program, and FAMIS;

4. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under § 2793 of the PHSA, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health benefit plan, coverage, or a determination under that plan or coverage; and

5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Marketplace and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and § 504 of the Rehabilitation Act as required by 45 C.F.R. § 155.210.

D. To be eligible to receive a grant under subsection C, a Navigator shall demonstrate to the Marketplace involved that it has existing relationships, or could readily establish relationships, with employers and employees, consumers, including uninsured and underinsured consumers, or self-employed individuals likely to be qualified to enroll in a qualified health plan.

E. Navigators shall include (i) at least one community and consumer-focused nonprofit group and (ii) at least one of the following groups: trade, industry, and professional associations; commercial fishing industry organizations; ranching and farming organizations; community and consumer-focused business development centers; other licensed insurance agents; and other entities that:

1. Are capable of carrying out the duties described in subsection C;

2. Meet the standards described in subsection F; and

3. Provide information consistent with the standards developed under subsection G.

F. The Commission shall by regulation establish standards for Navigators under this section, including provisions to ensure that any private or public entity that is selected as a Navigator is qualified to engage in the Navigator activities described in this section and to avoid conflicts of interest. Under such standards, a Navigator shall not (i) be a health carrier or (ii) receive any consideration directly or indirectly from any health carrier in connection with the enrollment of any individuals or employees in a qualified health plan or health benefit plan outside the Marketplace.

G. The Marketplace shall develop standards, consistent with any standards developed by the Secretary, to ensure that information made available by Navigators is fair, accurate, and impartial.

H. Navigators certified by the Marketplace pursuant to this section shall comply with all requirements of Article 7 (§ 38.2-3455 et seq.) of Chapter 34.

I. Grants to Navigators under this section shall be made from the operational funds of the Marketplace and not from federal funds received by the Commonwealth to establish the Marketplace.

§ 38.2-6414. Regulations.

The Commission shall promulgate regulations to implement the provisions of this chapter in accordance with the Commission's rules of practice and procedure. Regulations promulgated under this section shall be consistent with applicable provisions of federal and state law.

§ 38.2-6415. Relation to other laws.

Nothing in this chapter, and no action taken by the Marketplace pursuant to this chapter, shall be construed to preempt or supersede the authority of the Commission to regulate the business of insurance within the Commonwealth. Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans or qualified dental plans in the Commonwealth shall comply fully with all applicable health insurance laws of the Commonwealth and regulations adopted and orders issued by the Commission.

2. That the second enactment of Chapter 679 of the Acts of Assembly of 2013 is repealed.