CHAPTER 917

An Act to amend and reenact §§ 38.2-326, 38.2-3455, 38.2-3456, 38.2-3457, 38.2-3459, 38.2-3460, 38.2-4214, 38.2-4319, 38.2-4509, 58.1-3, and 58.1-341.1 of the Code of Virginia; to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 65, consisting of sections numbered 38.2-6500 through 38.2-6517; and to repeal the second enactment of Chapter 670 and the second enactment of Chapter 679 of the Acts of Assembly of 2013, relating to the establishment and operation of a health benefit exchange for the Commonwealth; assessments; Department of Taxation; information sharing.

[S 732]

Approved April 9, 2020

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-326, 38.2-3455, 38.2-3456, 38.2-3457, 38.2-3459, 38.2-3460, 38.2-4214, 38.2-4319, 38.2-4509, 58.1-3, and 58.1-341.1 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 65, consisting of sections numbered 38.2-6500 through 38.2-6517, as follows:

§ 38.2-326. Plan management functions.

A. *As used in this section:*

"Exchange" means either the (i) federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18041(c) in the Commonwealth or (ii) state-based exchange established pursuant to Chapter 65 (§ 38.2-6500 et seq.) and § 1311(b) of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18031.

"Plan management functions" means analyses and reviews necessary to support the certification, decertification, and recertification of qualified health plans and stand-alone dental plans for the participation in an exchange and the collection of data necessary to perform the above functions.

B. The ~~Commission~~ *Commission's Bureau of Insurance*, with the assistance of the Virginia Department of Health, shall perform plan management functions required to certify health benefit plans and stand-alone dental plans for participation in the ~~federal health benefit~~ exchange ~~established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18041(c) in the Commonwealth~~, provided that: (i) full funding is available; (ii) the technology infrastructure, including integration with federal, state, and other necessary entities, is made available to the Commission ~~by or through the U.S. Department of Health and Human Services or the Virginia Secretary of Health and Human Resources~~ in order for it to carry out the plan management functions authorized in this section; *and* (iii) there are no other impediments that effectively prevent the Commission from performing any required plan management functions~~; and (iv) the performance of such plan management functions is not deemed to establish a health benefit exchange pursuant to § 1311 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18031. For purposes of this section, "plan management functions" means analyses and reviews necessary to support the certification, decertification, and recertification of qualified health plans and stand-alone dental plans for the federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18041(c), and the collection of data necessary to perform the above functions~~.

~~B.~~ *C.* The ~~Commission~~ *Commission's Bureau of Insurance* may contract ~~with~~ and enter into memoranda of understanding to carry out its plan management functions ~~with the U.S. Department of Health and Human Services or any other state or federal agency, provided that entering into such contracts or memoranda of understanding are not deemed to establish a health benefit exchange pursuant to § 1311 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18031~~.

~~C. The Commission's obligation to perform plan management functions described in subsection A is contingent upon receiving federal funding sufficient to pay the operating expenses necessary to carry out the plan management functions. The Commission shall seek full reimbursement from the U.S. Department of Health and Human Services for such expenses.~~

D. The Commission shall not use any special fund revenues dedicated to its other functions and duties *unrelated to exchange operations*, including~~, but not limited to,~~ revenues from utility consumer taxes or fees from licensees or registrants regulated by the Commission or fees paid to the Clerk's Office, to fund the plan management functions.

E. Technology resources provided by the Commission in carrying out the plan management functions shall be limited to existing Commission technology support functions such as desktop support, network

administration support, web services support, or other similar support functions.

F. The Commission shall make available to the public on its website a written report on the implementation and performance of its plan management functions during the preceding fiscal year, including, at a minimum, the manner in which all funds utilized for its plan management functions were expended.

§ 38.2-3455. Definitions.

As used in this article, unless the context requires otherwise:

"Exchange" means ~~a health benefit exchange established or operated in the Commonwealth, including a health benefit exchange established or operated by the U.S. Secretary of Health and Human Services, pursuant to § 1311(b) of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended~~ *either a (i) federal health benefit exchange established by the Secretary of the U.S. Department of Health and Human Services pursuant to § 1321 of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18041(c) in the Commonwealth or (ii) state-based exchange established pursuant to Chapter 65 (§ 38.2-6500 et seq.) and § 1311 (b) of the Patient Protection and Affordable Care Act codified as 42 U.S.C. § 18031*.

"Health carrier" has the same meaning assigned to that term in § 38.2-3438.

"Navigator" means an individual or entity described in 42 U.S.C. § 1311(i)(2) that is selected to perform the activities and duties identified in 42 U.S.C. § 18031 (i) in the Commonwealth. "Navigator" does not include an individual or entity licensed as an agent under Chapter 18 (§ 38.2-1800 et seq.) of this title to sell, solicit, or negotiate contracts of insurance or annuity in the Commonwealth.

"Other affordable care options" means the programs provided under the state plan for medical assistance services pursuant to pursuant to Title XIX of the Social Security Act, as amended, and the Family Access to Medical Insurance Security (FAMIS) Plan developed pursuant to Title XXI of the Social Security Act, as amended.

"Qualified dental plan" means a limited scope dental plan that has in effect a certification that the plan meets the criteria for certification described in § 1311(d)(2)(B)(ii) of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

"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 Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

"Secretary" means the Secretary of the U.S. Department of Health and Human Services.

§ 38.2-3456. Prohibited activities.

A. A navigator shall not:

1. Engage in any activity that would require an insurance agent license under this title;

2. Offer advice about which qualified health plan or qualified dental plan is better or worse for a particular individual or employer;

3. Act as an intermediary between an employer and an insurer that offers a qualified health plan or qualified dental plan offered through an exchange;

4. Violate any unfair trade practice and privacy requirements in §§ 38.2-502, 38.2-503, 38.2-506, 38.2-509, 38.2-512, 38.2-515, 38.2-612.1, 38.2-613, and 38.2-614 to the extent such requirements are applicable to the activities of navigators; or

5. Receive compensation for services or duties as a navigator that are prohibited by federal law, including compensation from a health carrier.

B. An individual or entity shall not claim to be, or otherwise hold himself or itself out as, a navigator or conduct business as a navigator in the Commonwealth without:

1. Having been selected as a navigator in accordance with applicable federal *or state* law;

2. Having evidence of successful completion of all navigator requirements prescribed by the Secretary *or the Exchange*; and

3. Having met requirements established pursuant to § 38.2-3457.

C. If an individual or entity has engaged in the Commonwealth in one or more of the prohibited activities identified in this section, a complaint may be filed with the Commission. The Commission, upon investigation and verification of the prohibited activity or activities, may order such individual or entity to cease and desist such prohibited conduct.

§ 38.2-3457. Application for registration.

A. On or after September 1, 2014, no individual or entity shall act as a navigator in the Commonwealth unless such individual or entity has been certified by the U.S. Department of Health and Human Services *or the Exchange* and registered with the Commission.

B. An application for registration under this article shall be in the form and containing the information the Commission prescribes. Each applicant shall, at the time of applying for registration, pay a nonrefundable application processing fee in an amount and in a manner prescribed by the Commission. A criminal history record report shall accompany each individual registration application.

C. The Commission shall register the applicant if it finds that the character and general fitness of the applicant are such as to warrant belief that the applicant will act as a navigator fairly, in the public interest, and in accordance with law.

§ 38.2-3459. Grounds for termination, placing on probation, revocation, or suspension of registration.

A. If the Commission determines that a registered navigator has violated this article, or any order or regulation adopted thereunder, after notice and opportunity to be heard, the Commission may impose a penalty in accordance with §§ 38.2-218 and 38.2-219 and place on probation, suspend, or revoke any individual's or entity's registration.

B. The registration of any navigator shall terminate immediately when such navigator becomes decertified by the U.S. Department of Health and Human Services~~, whether or not the Commission has been notified of such decertification~~ *or the Exchange, as applicable*.

§ 38.2-3460. Sufficiency of federal requirements; additional standards and qualifications for navigators.

The Commission may determine whether the standards and qualifications for navigators provided by 42 U.S.C. § 18031 and any regulations enacted thereunder are sufficient to ensure that navigators can perform the required duties. If the Commission determines that the standards and qualifications are insufficient, the Commission shall ~~make a good faith effort to work in cooperation with the Secretary to propose improvements. If after a reasonable interval the Commission determines that the standards and qualifications remain insufficient, the Commission shall~~ adopt regulations establishing additional standards and qualifications to ensure that navigators can perform their required duties.

§ 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, 38.2-325, 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 38.2-1442, 38.2-1446, 38.2-1447, 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 38.2-3407.20, 38.2-3409, 38.2-3411 through 38.2-3419.1, 38.2-3430.1 through 38.2-3454, Article 8 (§ 38.2-3461 et seq.) of Chapter 34, 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 65 (§ 38.2-6500 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, 38.2-325, 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.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 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 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 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, Article 8 (§ 38.2-3461 et seq.) of Chapter 34, 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, 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 65 (§ 38.2-6500 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, 38.2-325, 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.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 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 65 (§ 38.2-6500 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, Articles 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 6 (§ 38.2-1335 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1442, 38.2-1446, 38.2-1447, 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, 38.2-3407.17:1, 38.2-3407.19, 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 65 (§ 38.2-6500 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 65.

VIRGINIA HEALTH BENEFIT EXCHANGE.

§ 38.2-6500. Definitions.

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

"American Health Benefit Exchange" means the program established as a component of the Exchange 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, a division within the Commission through which it administers insurance law.

"Certified application counselor" means individuals certified by the Exchange to perform the duties described in 45 C.F.R. § 155.255(c).

"Commission" means the State Corporation Commission.

"Committee" means the Advisory Committee established pursuant to § 38.2-6503.

"Director" means the Director of the Division appointed by the Commission pursuant to § 38.2-6502.

"Division" means the Health Benefit Exchange Division, a division within the Commission through which it administers the Exchange.

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

"Eligible entity" means the Bureau, the Department of Medical Assistance Services, or a qualified

vendor 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 package" means the scope of covered benefits and associated limits of a health benefit plan that (i) provides benefits pursuant to § 38.2-3451; (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.

"Exchange" means, as the context requires, either (i) the Division or (ii) the Virginia Health Benefit Exchange 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 Exchange and to qualified employers through the SHOP exchange. "Exchange," when referring to the Virginia Health Benefit Exchange, collectively refers to both the American Health Benefit Exchange and the SHOP exchange.

"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 as it may further be amended, 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 U.S. Social Security Act; coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq. (TRICARE); or similar supplemental coverage provided 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 health services plan, a dental plan organization, a dental services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Insurance agent" has the same meaning as provided in § 38.2-1800.

"Minimum essential coverage" means coverage defined in 45 C.F.R. § 156.600.

"Navigator" means an individual or entity that is registered pursuant to § 38.2-3457.

"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 § 38.2-6506.

"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 exchange 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 exchange to all of its eligible employees, wherever employed, or (ii) elects to provide coverage through the SHOP exchange 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 § 38.2-6506.

"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 Exchange; (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 U.S. Department of Health and Human Services.

"SHOP exchange" means the Small Business Health Options Program, established as a component of the Exchange 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 not more than 50 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 exchange 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 exchange 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.

§ 38.2-6501. Exchange objectives.

The Virginia Health Benefit Exchange shall make qualified health plans and qualified dental plans available to qualified individuals in the Commonwealth and 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 Exchange shall promote a transparent and competitive marketplace, promote consumer choice and education, and assist individuals with access to programs, policies and procedures, premium assistance tax credits, and cost-sharing reductions to support the continuity of coverage and reduce the number of uninsured.

§ 38.2-6502. Division established; Exchange created.

A. The Commission shall establish the Health Benefit Exchange Division as a separate division within the Commission. The Virginia Health Benefit Exchange shall be established and administered by the Commission, through the Division, in compliance with the requirements of this chapter and the Federal Act. The Exchange shall facilitate the purchase and sale of qualified health plans and qualified dental plans to qualified individuals and qualified employers. The Commission shall ensure that the Exchange and Bureau Divisions work in agreement to administer consistent regulation of Exchange plans.

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

C. The Commission, through the Division, shall have governing power and authority in any matter pertaining to the Exchange. 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 Exchange in the same manner as it does when performing its other regulatory, judicial, and administrative duties and responsibilities under this Code.

E. The Commission may adopt rules and regulations pursuant to § 38.2-223 as may be necessary or appropriate for the administration of the Exchange.

§ 38.2-6503. Advisory Committee.

A. There is hereby established an Advisory Committee in accordance with § 1311 (d) of the Federal Act and 45 C.F.R. § 155.110 to advise and provide recommendations to the Commission and the

Director in carrying out the purposes and duties of the Exchange. The Committee shall consist of up to 15 members. Members shall be appointed as follows: five nonlegislative citizen members to be appointed by the Governor, each of whom shall have demonstrated and acknowledged expertise in individual health coverage, small employer health coverage, health benefits plan administration, health care finance and economics, actuarial science, or with expertise in eligibility and enrollment in health care affordability programs and public health insurance; at least three nonlegislative citizen members appointed by the Commission, including an individual representing an organization that represents the Virginia insurance industry, an individual representing insurance agents, and a consumer representative; and any other members determined by the Commission. The Commissioner of Insurance, the Director of the Department of Medical Assistance Services, the State Health Commissioner, the Commissioner of the Department of Social Services, and the Secretary of Health and Human Resources, or their designees, shall serve as ex officio nonvoting members of the Committee.

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

C. A majority of the members appointed by the Governor and a majority of the members appointed by the Commission shall have no conflict of interest as set forth in the Federal Act.

D. After the initial staggering of terms, nonlegislative citizen members shall be appointed for a term of four years. No nonlegislative citizen member shall serve more than two consecutive four-year terms. The remainder of any term to which a member is appointed to fill a vacancy shall not constitute a term in determining the member's eligibility for reappointment.

E. The Committee shall elect a chairman and vice-chairman from among its membership. A majority of the appointed members shall constitute a quorum.

F. All meetings of the Committee shall be announced at least one week in advance on the Exchange 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 biennially. 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.

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

§ 38.2-6504. Exchange requirements.

A. The Exchange 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 January 1, 2023, unless the Commission determines that postponement of such date is necessary to complete the establishment of the Exchange. The Exchange shall not make available any health benefit plan that is not a qualified health plan. The Exchange shall allow a health carrier to offer a qualified dental plan either to supplement a qualified health plan or separately, as practicable.

B. The Exchange shall provide for the establishment of a SHOP exchange that will permit enrollment of eligible employees of qualified small employers in the Commonwealth directly through qualified health plan issuers, qualified dental plan issuers, or licensed agents that meet established Exchange standards.

C. The Exchange 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 Exchange, if the plan provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J) of the Federal Act.

D. Neither the Exchange nor a carrier offering qualified health benefit plans through the Exchange 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.

E. The Exchange and any associated programs shall be established and operated and offer plans in compliance with § 1321 (b) of the Federal Act.

§ 38.2-6505. Duties of Exchange.

The Exchange 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 § 38.2-6506;

2. Provide for enrollment periods 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 a website on which enrollees and prospective enrollees of qualified health plans and qualified dental plans may obtain standardized comparative information. Information on qualified health plans shall include, 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-level, silver-level, gold-level, 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 Exchange during certification processes; and (viii) the provider directory made available to the Exchange. 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 Exchange 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 Exchange, 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 Exchange through which qualified individuals may enroll in any qualified health plan or qualified dental plan offered through the American Health Benefit Exchange for which they are eligible and establish a SHOP exchange 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 exchange 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 exchange 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 Exchange, 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 Exchange under 42 U.S.C. § 18081 that the individual has changed employers and (ii) each individual who ceases coverage under a qualified health plan 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 Exchange 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 § 38.2-6513;

16. Consult with stakeholders relevant to carrying out the activities required under this chapter, including:

a. 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 use 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 Exchange's geographic area;

g. Public health experts;

h. Health care providers;

i. Large employers;

j. Health carriers; and

k. Insurance agents;

17. 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 Exchange;

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

(3) Require periodic reports in relation to the activities undertaken by the Exchange; 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 Exchange for staff retreats, promotional giveaways, excessive executive compensation, or promotion of federal or state legislative and regulatory modifications;

18. In collaboration with the Department of Medical Assistance Services, coordinate the operations of the Exchange with the operations of the state plan for medical assistance to determine initial and ongoing eligibility for those programs in a streamlined fashion; and

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

§ 38.2-6506. Certification of health benefit plans as qualified health plans.

A. The Exchange, in consultation with the Bureau, shall certify a health benefit plan as a qualified health plan, unless the Exchange determines that making the plan available through the Exchange 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 Exchange 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 Exchange;

2. The premium rates and policy forms 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;

5. The health carrier offering the plan:

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

b. Offers (i) at least one qualified health plan in the silver level of coverage and one qualified health plan at a gold level of coverage throughout each service area in which it offers coverage through the Exchange and (ii) a child-only plan at the same level of coverage as any qualified health plan offered through the Exchange to individuals who, as of the beginning of the plan year, are less than 21 years of age;

c. Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange 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 § 38.2-6504; and

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

6. The plan meets the requirements of certification as adopted by regulation pursuant to § 38.2-6514 or promulgated by the Secretary under § 1311(c) of the Federal Act, which include 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 Exchange 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 Exchange, or (iii) on the basis that the health benefit plan provides treatments necessary to prevent

patients' deaths in circumstances that the Exchange determines are inappropriate or too costly.

C. In order to foster a competitive marketplace and consumer choice, the Exchange shall certify all health benefit plans recommended by the Bureau meeting the requirements of § 1311(c) of the Federal Act for participation in the Exchange unless it is not in the interest of qualified individuals and qualified employers. The Exchange 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 Exchange.

D. The Exchange shall require each health carrier seeking certification of a health benefit plan as a qualified health plan to 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 Exchange's website and through other means for individuals without access to the Internet.

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

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 Exchange may specify or the Secretary may specify by regulation; and

3. Participants in the Exchange 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.

§ 38.2-6507. Appeal of decertification or denial of certification.

A. The Exchange 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 Exchange 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 Exchange 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.

D. Any final action or order of the Commission shall be subject to judicial review in accordance with the provisions of §§ 12.1-39, 12.1-40, and 12.1-41.

§ 38.2-6508. Open enrollment periods.

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

§ 38.2-6509. Choice.

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 an Exchange.

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(d) of the Federal Act:

1. This section shall not prohibit:

a. A health carrier from offering outside of an Exchange 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 an Exchange; 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 Exchange with respect to any requirement to offer benefits.

D. 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 an Exchange.

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

F. 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.

G. In accordance with § 1312(e) of the Federal Act, the Exchange may, for a licensed agent who agrees to comply with regulatory requirements, including advance registration with the Exchange, completion of training, and adherence to privacy and security standards set by the Exchange, allow such licensed agents:

1. To enroll qualified individuals and qualified employers in any qualified health plan or any qualified dental plan offered through the Exchange 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 Exchange.

§ 38.2-6510. Health Insurance Exchange Fund; assessment.

A. The Exchange shall be authorized to fund its operations through (i) special fund revenues generated by assessment fees on health carriers offering plans through the Exchange, (ii) funds described in subsection H, or (iii) such funds as the General Assembly may from time to time appropriate. All such funds received under this section and paid into the state treasury shall be deposited to a special fund designated "Health Insurance Exchange Special Fund State Corporation Commission." Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used solely for the purposes of supporting the Exchange through initial start-up costs associated with establishment of the Exchange, Exchange operations, outreach, and enrollment, a Navigator program, and other means of supporting the Exchange.

B. The Exchange shall have funding from the sources described in subsection A in an amount sufficient to support its ongoing operations.

C. Assessments on health carriers shall be reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. Assessments shall be approved by the Commission prior to implementation and shall not exceed three percent of the carrier's total monthly premium as described in this subsection, except that the Commission may, after notice and opportunity to be heard, adjust the assessment rate if necessary to ensure that the Exchange is fully funded. The assessment shall be based on the premium charged by a carrier for health benefits plans issued on the American Health Benefits Exchange and each qualified dental plan offered on the American Health Benefits Exchange during any period in which qualified health plans and qualified dental plans are effective on the American Health Benefits Exchange.

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

E. Taxes, fees, or assessments used to finance the Exchange 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. 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 Exchange.

G. A written report on the implementation and performance of the Exchange 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 Exchange.

H. The Exchange 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 Exchange.

I. The Commission shall not use any special fund revenues dedicated to its other functions and duties, including revenues from utility consumer taxes or fees from licensees regulated by the Commission, or fees paid to the office of the clerk of the Commission, to fund any of the activities or operating expenses of the Exchange.

§ 38.2-6511. 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 Exchange, 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 Exchange shall not enter into contracts with any health carrier or an affiliate of a health carrier.

C. Employees of the Exchange 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.

§ 38.2-6512. Confidentiality.

A. Notwithstanding any other provision of law, the records of the Exchange 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 Exchange, (ii) individuals' health information, (iii) information exchanged between the Exchange and any other state agency that is subject to confidentiality agreements under contracts entered into with the Exchange, and (iv) communications covered by an applicable legal or other privilege or such internal communications related to the Exchange that are designated confidential in regulations promulgated by the Commission to implement the provisions of this chapter.

B. The Exchange 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 that 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.

§ 38.2-6513. Navigators.

A. No person shall act as a Navigator unless the person is registered pursuant to Article 7 (§ 38.2-3455 et seq.) of Chapter 34 and is certified by either the U.S. Department of Health and Human Services or the Exchange.

B. The Exchange 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. Provide in-person assistance to 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 his health benefit plan, coverage, or a determination under that plan or coverage;

5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act (P.L. 101-336) and § 504 of the Rehabilitation Act as required by 45 C.F.R. § 155.210; and

6. Assist consumers with post-enrollment activities, including completing verification requests, accessing Special Enrollment Periods, accessing health insurance related tax forms, and assisting with complex cases and appeals.

C. To be eligible to receive a grant under subsection B, a Navigator shall demonstrate to the Exchange 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.

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

E. Navigators shall comply with all requirements of Article 7 (§ 38.2-3455 et seq.) of Chapter 34, including successful completion of training programs established by the Exchange for individual Navigators.

§ 38.2-6514. Certified application counselors.

A. The Exchange shall establish a Certified Application Counselor program pursuant to 45 C.F.R. § 155.225 and shall (i) certify individuals as certified application counselors to perform specified duties, (ii) designate an organization to certify individuals as certified application counselors to perform specified duties, or (iii) implement a combination both clause (i) and (ii).

B. The Exchange shall ensure, either directly or through designated organizations, that certified application counselors complete required Virginia-specific training on topics including qualified health plan options, insurance affordability programs, eligibility and enrollment rules, and all other regulatory requirements.

C. The Exchange shall ensure certified application counselors adhere to all terms and conditions of privacy and security pursuant to 45 C.F.R. § 155.260(b).

D. The Exchange may decertify a certified application counselor or designated organization for failure to comply with the requirements of this section or of the Exchange.

§ 38.2-6515. 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.

§ 38.2-6516. Reports.

The Exchange, in collaboration with the Secretary of Health and Human Resources, shall submit a report by November 1 of each year to the Chairs of the Senate Committees on Commerce and Labor and Finance and Appropriations and the House Committees on Labor and Commerce and Appropriations that shall include information on (i) Exchange operations and responsibilities, (ii) an accounting of the Exchange's finances, (iii) the effectiveness of the outreach and implementation activities of the Exchange in reducing the number of individuals without health insurance coverage, and (iv) other relevant information.

§ 38.2-6517. Relation to other laws.

Nothing in this chapter, and no action taken by the Exchange 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.

§ 58.1-3. Secrecy of information; penalties.

A. Except in accordance with a proper judicial order or as otherwise provided by law, the Tax Commissioner or agent, clerk, commissioner of the revenue, treasurer, or any other state or local tax or revenue officer or employee, or any person to whom tax information is divulged pursuant to this section or § 58.1-512 or 58.1-2712.2, or any former officer or employee of any of the aforementioned offices shall not divulge any information acquired by him in the performance of his duties with respect to the transactions, property, including personal property, income or business of any person, firm or corporation. Such prohibition specifically includes any copy of a federal return or federal return information required by Virginia law to be attached to or included in the Virginia return. This prohibition shall apply to any reports, returns, financial documents or other information filed with the Attorney General pursuant to the provisions of Article 3 (§ 3.2-4204 et seq.) of Chapter 42 of Title 3.2. Any person violating the provisions of this section is guilty of a Class 1 misdemeanor. The provisions of this subsection shall not be applicable, however, to:

1. Matters required by law to be entered on any public assessment roll or book;

2. Acts performed or words spoken, published, or shared with another agency or subdivision of the Commonwealth in the line of duty under state law;

3. Inquiries and investigations to obtain information as to the process of real estate assessments by a duly constituted committee of the General Assembly, or when such inquiry or investigation is relevant to its study, provided that any such information obtained shall be privileged;

4. The sales price, date of construction, physical dimensions or characteristics of real property, or any information required for building permits;

5. Copies of or information contained in an estate's probate tax return, filed with the clerk of court pursuant to § 58.1-1714, when requested by a beneficiary of the estate or an heir at law of the decedent or by the commissioner of accounts making a settlement of accounts filed in such estate;

6. Information regarding nonprofit entities exempt from sales and use tax under § 58.1-609.11, when requested by the General Assembly or any duly constituted committee of the General Assembly;

7. Reports or information filed with the Attorney General by a Stamping Agent pursuant to the provisions of Article 3 (§ 3.2-4204 et seq.), when such reports or information are provided by the Attorney General to a tobacco products manufacturer who is required to establish a qualified escrow fund pursuant to § 3.2-4201 and are limited to the brand families of that manufacturer as listed in the Tobacco Directory established pursuant to § 3.2-4206 and are limited to the current or previous two calendar years or in any year in which the Attorney General receives Stamping Agent information that potentially alters the required escrow deposit of the manufacturer. The information shall only be provided in the following manner: the manufacturer may make a written request, on a quarterly or yearly basis or when the manufacturer is notified by the Attorney General of a potential change in the amount of a required escrow deposit, to the Attorney General for a list of the Stamping Agents who reported stamping or selling its products and the amount reported. The Attorney General shall provide the list within 15 days of receipt of the request. If the manufacturer wishes to obtain actual copies of the reports the Stamping Agents filed with the Attorney General, it must first request them from the Stamping Agents pursuant to subsection C of § 3.2-4209. If the manufacturer does not receive the reports pursuant to subsection C of § 3.2-4209, the manufacturer may make a written request to the Attorney General, including a copy of the prior written request to the Stamping Agent and any response received, for copies of any reports not received. The Attorney General shall provide copies of the

reports within 45 days of receipt of the request.

B. 1. Nothing contained in this section shall be construed to prohibit the publication of statistics so classified as to prevent the identification of particular reports or returns and the items thereof or the publication of delinquent lists showing the names of taxpayers who are currently delinquent, together with any relevant information which in the opinion of the Department may assist in the collection of such delinquent taxes. Notwithstanding any other provision of this section or other law, the Department, upon request by the General Assembly or any duly constituted committee of the General Assembly, shall disclose the total aggregate amount of an income tax deduction or credit taken by all taxpayers, regardless of (i) how few taxpayers took the deduction or credit or (ii) any other circumstances. This section shall not be construed to prohibit a local tax official from disclosing whether a person, firm or corporation is licensed to do business in that locality and divulging, upon written request, the name and address of any person, firm or corporation transacting business under a fictitious name. Additionally, notwithstanding any other provision of law, the commissioner of revenue is authorized to provide, upon written request stating the reason for such request, the Tax Commissioner with information obtained from local tax returns and other information pertaining to the income, sales and property of any person, firm or corporation licensed to do business in that locality.

2. This section shall not prohibit the Department from disclosing whether a person, firm, or corporation is registered as a retail sales and use tax dealer pursuant to Chapter 6 (§ 58.1-600 et seq.) or whether a certificate of registration number relating to such tax is valid. Additionally, notwithstanding any other provision of law, the Department is hereby authorized to make available the names and certificate of registration numbers of dealers who are currently registered for retail sales and use tax.

3. This section shall not prohibit the Department from disclosing information to nongovernmental entities with which the Department has entered into a contract to provide services that assist it in the administration of refund processing or other services related to its administration of taxes.

4. This section shall not prohibit the Department from disclosing information to taxpayers regarding whether the taxpayer's employer or another person or entity required to withhold on behalf of such taxpayer submitted withholding records to the Department for a specific taxable year as required pursuant to subdivision C 1 of § 58.1-478.

5. This section shall not prohibit the commissioner of the revenue, treasurer, director of finance, or other similar local official who collects or administers taxes for a county, city, or town from disclosing information to nongovernmental entities with which the locality has entered into a contract to provide services that assist it in the administration of refund processing or other non-audit services related to its administration of taxes. The commissioner of the revenue, treasurer, director of finance, or other similar local official who collects or administers taxes for a county, city, or town shall not disclose information to such entity unless he has obtained a written acknowledgement by such entity that the confidentiality and nondisclosure obligations of and penalties set forth in subsection A apply to such entity and that such entity agrees to abide by such obligations.

C. Notwithstanding the provisions of subsection A or B or any other provision of this title, the Tax Commissioner is authorized to (i) divulge tax information to any commissioner of the revenue, director of finance, or other similar collector of county, city, or town taxes who, for the performance of his official duties, requests the same in writing setting forth the reasons for such request; (ii) provide to the Commissioner of the Department of Social Services, upon entering into a written agreement, the amount of income, filing status, number and type of dependents, and Forms W-2 and 1099 to facilitate the administration of public assistance or social services benefits as defined in § 63.2-100 or child support services pursuant to Chapter 19 (§ 63.2-1900 et seq.) of Title 63.2; (iii) provide to the chief executive officer of the designated student loan guarantor for the Commonwealth of Virginia, upon written request, the names and home addresses of those persons identified by the designated guarantor as having delinquent loans guaranteed by the designated guarantor; (iv) provide current address information upon request to state agencies and institutions for their confidential use in facilitating the collection of accounts receivable, and to the clerk of a circuit or district court for their confidential use in facilitating the collection of fines, penalties, and costs imposed in a proceeding in that court; (v) provide to the Commissioner of the Virginia Employment Commission, after entering into a written agreement, such tax information as may be necessary to facilitate the collection of unemployment taxes and overpaid benefits; (vi) provide to the Virginia Alcoholic Beverage Control Authority, upon entering into a written agreement, such tax information as may be necessary to facilitate the collection of state and local taxes and the administration of the alcoholic beverage control laws; (vii) provide to the Director of the Virginia Lottery such tax information as may be necessary to identify those lottery ticket retailers who owe delinquent taxes; (viii) provide to the Department of the Treasury for its confidential use such tax information as may be necessary to facilitate the location of owners and holders of unclaimed property, as defined in § 55.1-2500; (ix) provide to the State Corporation Commission, upon entering into a written agreement, such tax information as may be necessary to facilitate the collection of taxes and fees administered by the Commission; (x) provide to the Executive Director of the Potomac and Rappahannock Transportation Commission for his confidential use such tax information as may be necessary to facilitate the collection of the motor vehicle fuel sales tax; (xi) provide to the

Commissioner of the Department of Agriculture and Consumer Services such tax information as may be necessary to identify those applicants for registration as a supplier of charitable gaming supplies who have not filed required returns or who owe delinquent taxes; (xii) provide to the Department of Housing and Community Development for its confidential use such tax information as may be necessary to facilitate the administration of the remaining effective provisions of the Enterprise Zone Act (§ 59.1-270 et seq.), and the Enterprise Zone Grant Program (§ 59.1-538 et seq.); (xiii) provide current name and address information to private collectors entering into a written agreement with the Tax Commissioner, for their confidential use when acting on behalf of the Commonwealth or any of its political subdivisions; however, the Tax Commissioner is not authorized to provide such information to a private collector who has used or disseminated in an unauthorized or prohibited manner any such information previously provided to such collector; (xiv) provide current name and address information as to the identity of the wholesale or retail dealer that affixed a tax stamp to a package of cigarettes to any person who manufactures or sells at retail or wholesale cigarettes and who may bring an action for injunction or other equitable relief for violation of Chapter 10.1, Enforcement of Illegal Sale or Distribution of Cigarettes Act; (xv) provide to the Commissioner of Labor and Industry, upon entering into a written agreement, such tax information as may be necessary to facilitate the collection of unpaid wages under § 40.1-29; (xvi) provide to the Director of the Department of Human Resource Management, upon entering into a written agreement, such tax information as may be necessary to identify persons receiving workers' compensation indemnity benefits who have failed to report earnings as required by § 65.2-712; (xvii) provide to any commissioner of the revenue, director of finance, or any other officer of any county, city, or town performing any or all of the duties of a commissioner of the revenue and to any dealer registered for the collection of the Communications Sales and Use Tax, a list of the names, business addresses, and dates of registration of all dealers registered for such tax; (xviii) provide to the Executive Director of the Northern Virginia Transportation Commission for his confidential use such tax information as may be necessary to facilitate the collection of the motor vehicle fuel sales tax; (xix) provide to the Commissioner of Agriculture and Consumer Services the name and address of the taxpayer businesses licensed by the Commonwealth that identify themselves as subject to regulation by the Board of Agriculture and Consumer Services pursuant to § 3.2-5130; (xx) provide to the developer or the economic development authority of a tourism project authorized by § 58.1-3851.1, upon entering into a written agreement, tax information facilitating the repayment of gap financing; ~~and~~ (xxi) provide to the Virginia Retirement System and the Department of Human Resource Management, after entering into a written agreement, such tax information as may be necessary to facilitate the enforcement of subdivision C 4 of § 9.1-401*; and (xxii) provide to the Department of Medical Assistance Services, upon entering into a written agreement, the name, address, social security number, number and type of personal exemptions, tax-filing status, and adjusted gross income of an individual, or spouse in the case of a married taxpayer filing jointly, who has voluntarily consented to such disclosure for purposes of identifying persons who would like to newly enroll in medical assistance*. The Tax Commissioner is further authorized to enter into written agreements with duly constituted tax officials of other states and of the United States for the inspection of tax returns, the making of audits, and the exchange of information relating to any tax administered by the Department of Taxation. Any person to whom tax information is divulged pursuant to this section shall be subject to the prohibitions and penalties prescribed herein as though he were a tax official.

D. Notwithstanding the provisions of subsection A or B or any other provision of this title, the commissioner of revenue or other assessing official is authorized to (i) provide, upon written request stating the reason for such request, the chief executive officer of any county or city with information furnished to the commissioner of revenue by the Tax Commissioner relating to the name and address of any dealer located within the county or city who paid sales and use tax, for the purpose of verifying the local sales and use tax revenues payable to the county or city; (ii) provide to the Department of Professional and Occupational Regulation for its confidential use the name, address, and amount of gross receipts of any person, firm or entity subject to a criminal investigation of an unlawful practice of a profession or occupation administered by the Department of Professional and Occupational Regulation, only after the Department of Professional and Occupational Regulation exhausts all other means of obtaining such information; and (iii) provide to any representative of a condominium unit owners' association, property owners' association or real estate cooperative association, or to the owner of property governed by any such association, the names and addresses of parties having a security interest in real property governed by any such association; however, such information shall be released only upon written request stating the reason for such request, which reason shall be limited to proposing or opposing changes to the governing documents of the association, and any information received by any person under this subsection shall be used only for the reason stated in the written request. The treasurer or other local assessing official may require any person requesting information pursuant to clause (iii) of this subsection to pay the reasonable cost of providing such information. Any person to whom tax information is divulged pursuant to this subsection shall be subject to the prohibitions and penalties prescribed herein as though he were a tax official.

Notwithstanding the provisions of subsection A or B or any other provisions of this title, the

treasurer or other collector of taxes for a county, city or town is authorized to provide information relating to any motor vehicle, trailer or semitrailer obtained by such treasurer or collector in the course of performing his duties to the commissioner of the revenue or other assessing official for such jurisdiction for use by such commissioner or other official in performing assessments.

This section shall not be construed to prohibit a local tax official from imprinting or displaying on a motor vehicle local license decal the year, make, and model and any other legal identification information about the particular motor vehicle for which that local license decal is assigned.

E. Notwithstanding any other provisions of law, state agencies and any other administrative or regulatory unit of state government shall divulge to the Tax Commissioner or his authorized agent, upon written request, the name, address, and social security number of a taxpayer, necessary for the performance of the Commissioner's official duties regarding the administration and enforcement of laws within the jurisdiction of the Department of Taxation. The receipt of information by the Tax Commissioner or his agent which may be deemed taxpayer information shall not relieve the Commissioner of the obligations under this section.

F. Additionally, it shall be unlawful for any person to disseminate, publish, or cause to be published any confidential tax document which he knows or has reason to know is a confidential tax document. A confidential tax document is any correspondence, document, or tax return that is prohibited from being divulged by subsection A, B, C, or D and includes any document containing information on the transactions, property, income, or business of any person, firm, or corporation that is required to be filed with any state official by § 58.1-512. This prohibition shall not apply if such confidential tax document has been divulged or disseminated pursuant to a provision of law authorizing disclosure. Any person violating the provisions of this subsection is guilty of a Class 1 misdemeanor.

§ 58.1-341.1. Returns of individuals; required information.

A. For all taxable years beginning on and after January 1, 1995, the Department of Taxation shall include in any packet of instructions and forms for individual income tax returns an application to register to vote by mail and appropriate instructions for the completion and mailing of the application to register to vote. The form of the application shall be prescribed and the instructions shall be provided by the State Board of Elections.

B. For all taxable years beginning on and after January 1, 2021, the Department of Taxation shall include on the appropriate individual income tax return forms a checkoff box or similar mechanism for indicating whether the individual, or spouse in the case of a married taxpayer filing jointly, or any dependent of the individual (i) is an uninsured individual at the time the return is filed and (ii) voluntarily consents to the Department of Taxation providing the individual's tax information, as provided in clause (xxii) of subsection C of § 58.1-3, to the Department of Medical Assistance Services for purposes of affirming that the individual, the individual's spouse, or any dependent of the individual meets the income eligibility for medical assistance. Such information shall not be used to determine an individual is ineligible for medical assistance.

2. That the second enactment of Chapter 670 and the second enactment of Chapter 679 of the Acts of Assembly of 2013 are repealed.

3. That the Secretary of Health and Human Resources shall convene a work group that includes representatives from the State Corporation Commission, the Department of Medical Assistance Services, the Department of Social Services, and the Department of Taxation and a consumer advocate with expertise in health program eligibility and enrollment to develop systems, policies, and practices to leverage state income tax returns to facilitate the enrollment of eligible individuals in insurance affordability programs through the Virginia Health Benefit Exchange established by this act. The Secretary shall report the work group's recommendations to the Governor and the General Assembly by September 15, 2020.

4. That the initial appointments of nonlegislative citizen members to the Advisory Committee (Committee) established pursuant to § 38.2-6503 of the Code of Virginia, as created by this act, shall be staggered as follows: two members appointed by the Governor and one member appointed by the State Corporation Commission (Commission) for a term of four years; one member appointed by the Governor and one member appointed by the Commission for a term of three years; one member appointed by the Governor and one member appointed by the Commission for a term of two years; and one member appointed by the Governor for a term of one year. The Commission shall consider the continuity of the Committee if the Commission elects to make additional appointments, as authorized in § 38.2-6503 of the Code of Virginia, as created by this act.

5. That the State Corporation Commission shall implement the provisions of this act as it receives notice of approval by the Centers for Medicare and Medicaid Services and to the extent of such approval.