CHAPTER 560

An Act to amend and reenact § 38.2-6506 of the Code of Virginia, relating to qualified health plans; essential health benefits; state-mandated health benefits.

[H 431]

Approved April 11, 2022

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-6506 of the Code of Virginia is amended and reenacted as follows:

§ 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 *health benefits in* the essential health benefits package~~, except that (i) the~~. *The* plan ~~shall not~~ *may* provide any state-mandated health benefit that is not provided in the essential health benefits package ~~and (ii) the~~. *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)~~ *(i)* the Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage and ~~(b)~~ *(ii)* 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.