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HOUSE BILL NO. 357

Offered January 11, 2012

Prefiled January 10, 2012

A BILL to amend and reenact §§ 2.2-2818, 2.2-2905, 2.2-3705.7, 2.2-3711, 2.2-4002, 2.2-4343, 32.1-16, 32.1-321.1, 38.2-200, 38.2-316, 38.2-3522.1, 38.2-3523.4, and 63.2-206 of the Code of Virginia and to amend the Code of Virginia by adding sections numbered 38.2-1809.1, 38.2-3430.1:2, and 38.2-3510.1 and by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6431, relating to the creation of the Virginia Health Benefit Exchange Authority and the establishment and operation of a health benefit exchange for the Commonwealth; assessments; rules applicable to health care plans offered outside the health benefit exchange; duties of state agencies.

Patrons—McClellan, Carr, Filler-Corn, Hope, Kory, Toscano and Watts

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That §§ 2.2-2818, 2.2-2905, 2.2-3705.7, 2.2-3711, 2.2-4002, 2.2-4343, 32.1-16, 32.1-321.1, 38.2-200, 38.2-316, 38.2-3522.1, 38.2-3523.4, and 63.2-206 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding sections numbered 38.2-1809.1, 38.2-3430.1:2, and 38.2-3510.1 and by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6431, as follows:

§ 2.2-2818. Health and related insurance for state employees.

A. The Department of Human Resource Management shall establish a plan, subject to the approval of the Governor, for providing health insurance coverage, including chiropractic treatment, hospitalization, medical, surgical and major medical coverage, for state employees and retired state employees with the Commonwealth paying the cost thereof to the extent of the coverage included in such plan. The same plan shall be offered to all part-time state employees, but the total cost shall be paid by such part-time employees. The Department of Human Resource Management shall administer this section. The plan chosen shall provide means whereby coverage for the families or dependents of state employees may be purchased. Except for part-time employees, the Commonwealth may pay all or a portion of the cost thereof, and for such portion as the Commonwealth does not pay, the employee, including a part-time employee, may purchase the coverage by paying the additional cost over the cost of coverage for an employee.

Such contribution shall be financed through appropriations provided by law.

B. The plan shall:

1. Include coverage for low-dose screening mammograms for determining the presence of occult breast cancer. Such coverage shall make available one screening mammogram to persons age 35 through 39, one such mammogram biennially to persons age 40 through 49, and one such mammogram annually to persons age 50 and over and may be limited to a benefit of $50 per mammogram subject to such dollar limits, deductibles, and coinsurance factors as are no less favorable than for physical illness generally.

The term "mammogram" shall mean an X-ray examination of the breast using equipment dedicated specifically for mammography, including but not limited to the X-ray tube, filter, compression device, screens, film, and cassettes, with an average radiation exposure of less than one rad mid-breast, two views of each breast.

In order to be considered a screening mammogram for which coverage shall be made available under this section:

a. The mammogram shall be (i) ordered by a health care practitioner acting within the scope of his licensure and, in the case of an enrollee of a health maintenance organization, by the health maintenance organization provider; (ii) performed by a registered technologist; (iii) interpreted by a qualified radiologist; and (iv) performed under the direction of a person licensed to practice medicine and surgery and certified by the American Board of Radiology or an equivalent examining body. A copy of the mammogram report shall be sent or delivered to the health care practitioner who ordered it;

b. The equipment used to perform the mammogram shall meet the standards set forth by the Virginia Department of Health in its radiation protection regulations; and

c. The mammography film shall be retained by the radiologic facility performing the examination in accordance with the American College of Radiology guidelines or state law.

2. Include coverage for postpartum services providing inpatient care and a home visit or visits that

shall be in accordance with the medical criteria, outlined in the most current version of or an official update to the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists or the "Standards for Obstetric-Gynecologic Services" prepared by the American College of Obstetricians and Gynecologists. Such coverage shall be provided incorporating any changes in such Guidelines or Standards within six months of the publication of such Guidelines or Standards or any official amendment thereto.

3. Include an appeals process for resolution of written complaints concerning denials or partial denials of claims that shall provide reasonable procedures for resolution of such written complaints and shall be published and disseminated to all covered state employees. The appeals process shall include a separate expedited emergency appeals procedure that shall provide resolution within one business day of receipt of a complaint concerning situations requiring immediate medical care. For appeals involving adverse decisions as defined in § 32.1-137.7, the Department shall contract with one or more impartial health entities to review such decisions. Impartial health entities may include medical peer review organizations and independent utilization review companies. The Department shall adopt regulations to assure that the impartial health entity conducting the reviews has adequate standards, credentials and experience for such review. The impartial health entity shall examine the final denial of claims to determine whether the decision is objective, clinically valid, and compatible with established principles of health care. The decision of the impartial health entity shall (i) be in writing, (ii) contain findings of fact as to the material issues in the case and the basis for those findings, and (iii) be final and binding if consistent with law and policy.

Prior to assigning an appeal to an impartial health entity, the Department shall verify that the impartial health entity conducting the review of a denial of claims has no relationship or association with (i) the covered employee; (ii) the treating health care provider, or any of its employees or affiliates; (iii) the medical care facility at which the covered service would be provided, or any of its employees or affiliates; or (iv) the development or manufacture of the drug, device, procedure or other therapy that is the subject of the final denial of a claim. The impartial health entity shall not be a subsidiary of, nor owned or controlled by, a health plan, a trade association of health plans, or a professional association of health care providers. There shall be no liability on the part of and no cause of action shall arise against any officer or employee of an impartial health entity for any actions taken or not taken or statements made by such officer or employee in good faith in the performance of his powers and duties.

4. Include coverage for early intervention services. For purposes of this section, "early intervention services" means medically necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices for dependents from birth to age three who are certified by the Department of Behavioral Health and Developmental Services as eligible for services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.). Medically necessary early intervention services for the population certified by the Department of Behavioral Health and Developmental Services shall mean those services designed to help an individual attain or retain the capability to function age-appropriately within his environment, and shall include services that enhance functional ability without effecting a cure.

For persons previously covered under the plan, there shall be no denial of coverage due to the existence of a preexisting condition. The cost of early intervention services shall not be applied to any contractual provision limiting the total amount of coverage paid by the insurer to or on behalf of the insured during the insured's lifetime.

5. Include coverage for prescription drugs and devices approved by the United States Food and Drug Administration for use as contraceptives.

6. Not deny coverage for any drug approved by the United States Food and Drug Administration for use in the treatment of cancer on the basis that the drug has not been approved by the United States Food and Drug Administration for the treatment of the specific type of cancer for which the drug has been prescribed, if the drug has been recognized as safe and effective for treatment of that specific type of cancer in one of the standard reference compendia.

7. Not deny coverage for any drug prescribed to treat a covered indication so long as the drug has been approved by the United States Food and Drug Administration for at least one indication and the drug is recognized for treatment of the covered indication in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature.

8. Include coverage for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy, for the treatment of insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and noninsulin-using diabetes if prescribed by a healthcare professional legally authorized to prescribe such items under law. To qualify for coverage under this subdivision, diabetes outpatient self-management training and education shall be provided by a certified, registered or licensed health care professional.

9. Include coverage for reconstructive breast surgery. For purposes of this section, "reconstructive breast surgery" means surgery performed on and after July 1, 1998, (i) coincident with a mastectomy

performed for breast cancer or (ii) following a mastectomy performed for breast cancer to reestablish symmetry between the two breasts. For persons previously covered under the plan, there shall be no denial of coverage due to preexisting conditions.

10. Include coverage for annual pap smears, including coverage, on and after July 1, 1999, for annual testing performed by any FDA-approved gynecologic cytology screening technologies.

11. Include coverage providing a minimum stay in the hospital of not less than 48 hours for a patient following a radical or modified radical mastectomy and 24 hours of inpatient care following a total mastectomy or a partial mastectomy with lymph node dissection for treatment of breast cancer. Nothing in this subdivision shall be construed as requiring the provision of inpatient coverage where the attending physician in consultation with the patient determines that a shorter period of hospital stay is appropriate.

12. Include coverage (i) to persons age 50 and over and (ii) to persons age 40 and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society, for one PSA test in a 12-month period and digital rectal examinations, all in accordance with American Cancer Society guidelines. For the purpose of this subdivision, "PSA testing" means the analysis of a blood sample to determine the level of prostate specific antigen.

13. Permit any individual covered under the plan direct access to the health care services of a participating specialist (i) authorized to provide services under the plan and (ii) selected by the covered individual. The plan shall have a procedure by which an individual who has an ongoing special condition may, after consultation with the primary care physician, receive a referral to a specialist for such condition who shall be responsible for and capable of providing and coordinating the individual's primary and specialty care related to the initial specialty care referral. If such an individual's care would most appropriately be coordinated by such a specialist, the plan shall refer the individual to a specialist. For the purposes of this subdivision, "special condition" means a condition or disease that is (i) life-threatening, degenerative, or disabling and (ii) requires specialized medical care over a prolonged period of time. Within the treatment period authorized by the referral, such specialist shall be permitted to treat the individual without a further referral from the individual's primary care provider and may authorize such referrals, procedures, tests, and other medical services related to the initial referral as the individual's primary care provider would otherwise be permitted to provide or authorize. The plan shall have a procedure by which an individual who has an ongoing special condition that requires ongoing care from a specialist may receive a standing referral to such specialist for the treatment of the special condition. If the primary care provider, in consultation with the plan and the specialist, if any, determines that such a standing referral is appropriate, the plan or issuer shall make such a referral to a specialist. Nothing contained herein shall prohibit the plan from requiring a participating specialist to provide written notification to the covered individual's primary care physician of any visit to such specialist. Such notification may include a description of the health care services rendered at the time of the visit.

14. Include provisions allowing employees to continue receiving health care services for a period of up to 90 days from the date of the primary care physician's notice of termination from any of the plan's provider panels. The plan shall notify any provider at least 90 days prior to the date of termination of the provider, except when the provider is terminated for cause.

For a period of at least 90 days from the date of the notice of a provider's termination from any of the plan's provider panels, except when a provider is terminated for cause, a provider shall be permitted by the plan to render health care services to any of the covered employees who (i) were in an active course of treatment from the provider prior to the notice of termination and (ii) request to continue receiving health care services from the provider.

Notwithstanding the provisions of this subdivision, any provider shall be permitted by the plan to continue rendering health services to any covered employee who has entered the second trimester of pregnancy at the time of the provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue through the provision of postpartum care directly related to the delivery.

Notwithstanding the provisions of this subdivision, any provider shall be permitted to continue rendering health services to any covered employee who is determined to be terminally ill (as defined under § 1861(dd)(3)(A) of the Social Security Act) at the time of a provider's termination of participation, except when a provider is terminated for cause. Such treatment shall, at the covered employee's option, continue for the remainder of the employee's life for care directly related to the treatment of the terminal illness.

A provider who continues to render health care services pursuant to this subdivision shall be reimbursed in accordance with the carrier's agreement with such provider existing immediately before the provider's termination of participation.

15. Include coverage for patient costs incurred during participation in clinical trials for treatment

studies on cancer, including ovarian cancer trials.

The reimbursement for patient costs incurred during participation in clinical trials for treatment studies on cancer shall be determined in the same manner as reimbursement is determined for other medical and surgical procedures. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally.

For purposes of this subdivision:

"Cooperative group" means a formal network of facilities that collaborate on research projects and have an established NIH-approved peer review program operating within the group. "Cooperative group" includes (i) the National Cancer Institute Clinical Cooperative Group and (ii) the National Cancer Institute Community Clinical Oncology Program.

"FDA" means the Federal Food and Drug Administration.

"Multiple project assurance contract" means a contract between an institution and the federal Department of Health and Human Services that defines the relationship of the institution to the federal Department of Health and Human Services and sets out the responsibilities of the institution and the procedures that will be used by the institution to protect human subjects.

"NCI" means the National Cancer Institute.

"NIH" means the National Institutes of Health.

"Patient" means a person covered under the plan established pursuant to this section.

"Patient cost" means the cost of a medically necessary health care service that is incurred as a result of the treatment being provided to a patient for purposes of a clinical trial. "Patient cost" does not include (i) the cost of nonhealth care services that a patient may be required to receive as a result of the treatment being provided for purposes of a clinical trial, (ii) costs associated with managing the research associated with the clinical trial, or (iii) the cost of the investigational drug or device.

Coverage for patient costs incurred during clinical trials for treatment studies on cancer shall be provided if the treatment is being conducted in a Phase II, Phase III, or Phase IV clinical trial. Such treatment may, however, be provided on a case-by-case basis if the treatment is being provided in a Phase I clinical trial.

The treatment described in the previous paragraph shall be provided by a clinical trial approved by:

a. The National Cancer Institute;

b. An NCI cooperative group or an NCI center;

c. The FDA in the form of an investigational new drug application;

d. The federal Department of Veterans Affairs; or

e. An institutional review board of an institution in the Commonwealth that has a multiple project assurance contract approved by the Office of Protection from Research Risks of the NCI.

The facility and personnel providing the treatment shall be capable of doing so by virtue of their experience, training, and expertise.

Coverage under this subdivision shall apply only if:

(1) There is no clearly superior, noninvestigational treatment alternative;

(2) The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative; and

(3) The patient and the physician or health care provider who provides services to the patient under the plan conclude that the patient's participation in the clinical trial would be appropriate, pursuant to procedures established by the plan.

16. Include coverage providing a minimum stay in the hospital of not less than 23 hours for a covered employee following a laparoscopy-assisted vaginal hysterectomy and 48 hours for a covered employee following a vaginal hysterectomy, as outlined in Milliman & Robertson's nationally recognized guidelines. Nothing in this subdivision shall be construed as requiring the provision of the total hours referenced when the attending physician, in consultation with the covered employee, determines that a shorter hospital stay is appropriate.

17. Include coverage for biologically based mental illness.

For purposes of this subdivision, a "biologically based mental illness" is any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's functioning; specifically, the following diagnoses are defined as biologically based mental illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

Coverage for biologically based mental illnesses shall neither be different nor separate from coverage for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayment and coinsurance factors.

Nothing shall preclude the undertaking of usual and customary procedures to determine the

appropriateness of, and medical necessity for, treatment of biologically based mental illnesses under this option, provided that all such appropriateness and medical necessity determinations are made in the same manner as those determinations made for the treatment of any other illness, condition or disorder covered by such policy or contract.

In no case, however, shall coverage for mental disorders provided pursuant to this section be diminished or reduced below the coverage in effect for such disorders on January 1, 1999.

18. Offer and make available coverage for the treatment of morbid obesity through gastric bypass surgery or such other methods as may be recognized by the National Institutes of Health as effective for the long-term reversal of morbid obesity. Such coverage shall have durational limits, dollar limits, deductibles, copayments and coinsurance factors that are no less favorable than for physical illness generally. Access to surgery for morbid obesity shall not be restricted based upon dietary or any other criteria not approved by the National Institutes of Health. For purposes of this subdivision, "morbid obesity" means (i) a weight that is at least 100 pounds over or twice the ideal weight for frame, age, height, and gender as specified in the 1983 Metropolitan Life Insurance tables, (ii) a body mass index (BMI) equal to or greater than 35 kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or diabetes, or (iii) a BMI of 40 kilograms per meter squared without such comorbidity. As used herein, "BMI" equals weight in kilograms divided by height in meters squared.

19. Include coverage for colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations. The coverage for colorectal cancer screening shall not be more restrictive than or separate from coverage provided for any other illness, condition or disorder for purposes of determining deductibles, benefit year or lifetime durational limits, benefit year or lifetime dollar limits, lifetime episodes or treatment limits, copayment and coinsurance factors, and benefit year maximum for deductibles and copayments and coinsurance factors.

20. On and after July 1, 2002, require that a prescription benefit card, health insurance benefit card, or other technology that complies with the requirements set forth in § 38.2-3407.4:2 be issued to each employee provided coverage pursuant to this section, and shall upon any changes in the required data elements set forth in subsection A of § 38.2-3407.4:2, either reissue the card or provide employees covered under the plan such corrective information as may be required to electronically process a prescription claim.

21. Include coverage for infant hearing screenings and all necessary audiological examinations provided pursuant to § 32.1-64.1 using any technology approved by the United States Food and Drug Administration, and as recommended by the national Joint Committee on Infant Hearing in its most current position statement addressing early hearing detection and intervention programs. Such coverage shall include follow-up audiological examinations as recommended by a physician, physician assistant, nurse practitioner or audiologist and performed by a licensed audiologist to confirm the existence or absence of hearing loss.

22. Notwithstanding any provision of this section to the contrary, every plan established in accordance with this section shall comply with the provisions of § 2.2-2818.2.

C. Claims incurred during a fiscal year but not reported during that fiscal year shall be paid from such funds as shall be appropriated by law. Appropriations, premiums and other payments shall be deposited in the employee health insurance fund, from which payments for claims, premiums, cost containment programs and administrative expenses shall be withdrawn from time to time. The funds of the health insurance fund shall be deemed separate and independent trust funds, shall be segregated from all other funds of the Commonwealth, and shall be invested and administered solely in the interests of the employees and their beneficiaries. Neither the General Assembly nor any public officer, employee, or agency shall use or authorize the use of such trust funds for any purpose other than as provided in law for benefits, refunds, and administrative expenses, including but not limited to legislative oversight of the health insurance fund.

D. For the purposes of this section:

"Part-time state employees" means classified or similarly situated employees in legislative, executive, judicial or independent agencies who are compensated on a salaried basis and work at least 20 hours, but less than 32 hours, per week.

"Peer-reviewed medical literature" means a scientific study published only after having been critically reviewed for scientific accuracy, validity, and reliability by unbiased independent experts in a journal that has been determined by the International Committee of Medical Journal Editors to have met the Uniform Requirements for Manuscripts submitted to biomedical journals. Peer-reviewed medical literature does not include publications or supplements to publications that are sponsored to a significant

extent by a pharmaceutical manufacturing company or health carrier.

"Standard reference compendia" means:

1. American Hospital Formulary Service - Drug Information;

2. National Comprehensive Cancer Network's Drugs & Biologics Compendium; or

3. Elsevier Gold Standard's Clinical Pharmacology.

"State employee" means state employee as defined in § 51.1-124.3; employee as defined in § 51.1-201; the Governor, Lieutenant Governor and Attorney General; judge as defined in § 51.1-301 and judges, clerks and deputy clerks of regional juvenile and domestic relations, county juvenile and domestic relations, and district courts of the Commonwealth; ~~and~~ interns and residents employed by the School of Medicine and Hospital of the University of Virginia, and interns, residents, and employees of the Virginia Commonwealth University Health System Authority as provided in § 23-50.16:24*; and employees of the Virginia Health Benefit Exchange Authority*.

E. Provisions shall be made for retired employees to obtain coverage under the above plan, including, as an option, coverage for vision and dental care. The Commonwealth may, but shall not be obligated to, pay all or any portion of the cost thereof.

F. Any self-insured group health insurance plan established by the Department of Human Resource Management that utilizes a network of preferred providers shall not exclude any physician solely on the basis of a reprimand or censure from the Board of Medicine, so long as the physician otherwise meets the plan criteria established by the Department.

G. The plan shall include, in each planning district, at least two health coverage options, each sponsored by unrelated entities. No later than July 1, 2006, one of the health coverage options to be available in each planning district shall be a high deductible health plan that would qualify for a health savings account pursuant to § 223 of the Internal Revenue Code of 1986, as amended.

In each planning district that does not have an available health coverage alternative, the Department shall voluntarily enter into negotiations at any time with any health coverage provider who seeks to provide coverage under the plan.

This subsection shall not apply to any state agency authorized by the Department to establish and administer its own health insurance coverage plan separate from the plan established by the Department.

H. Any self-insured group health insurance plan established by the Department of Human Resource Management that includes coverage for prescription drugs on an outpatient basis may apply a formulary to the prescription drug benefits provided by the plan if the formulary is developed, reviewed at least annually, and updated as necessary in consultation with and with the approval of a pharmacy and therapeutics committee, a majority of whose members are actively practicing licensed (i) pharmacists, (ii) physicians, and (iii) other health care providers.

If the plan maintains one or more drug formularies, the plan shall establish a process to allow a person to obtain, without additional cost-sharing beyond that provided for formulary prescription drugs in the plan, a specific, medically necessary nonformulary prescription drug if, after reasonable investigation and consultation with the prescriber, the formulary drug is determined to be an inappropriate therapy for the medical condition of the person. The plan shall act on such requests within one business day of receipt of the request.

Any plan established in accordance with this section shall be authorized to provide for the selection of a single mail order pharmacy provider as the exclusive provider of pharmacy services that are delivered to the covered person's address by mail, common carrier, or delivery service. As used in this subsection, "mail order pharmacy provider" means a pharmacy permitted to conduct business in the Commonwealth whose primary business is to dispense a prescription drug or device under a prescriptive drug order and to deliver the drug or device to a patient primarily by mail, common carrier, or delivery service.

I. Any plan established in accordance with this section requiring preauthorization prior to rendering medical treatment shall have personnel available to provide authorization at all times when such preauthorization is required.

J. Any plan established in accordance with this section shall provide to all covered employees written notice of any benefit reductions during the contract period at least 30 days before such reductions become effective.

K. No contract between a provider and any plan established in accordance with this section shall include provisions that require a health care provider or health care provider group to deny covered services that such provider or group knows to be medically necessary and appropriate that are provided with respect to a covered employee with similar medical conditions.

L. The Department of Human Resource Management shall appoint an Ombudsman to promote and protect the interests of covered employees under any state employee's health plan.

The Ombudsman shall:

1. Assist covered employees in understanding their rights and the processes available to them according to their state health plan.

2. Answer inquiries from covered employees by telephone and electronic mail.

3. Provide to covered employees information concerning the state health plans.

4. Develop information on the types of health plans available, including benefits and complaint procedures and appeals.

5. Make available, either separately or through an existing Internet web site utilized by the Department of Human Resource Management, information as set forth in subdivision 4 and such additional information as he deems appropriate.

6. Maintain data on inquiries received, the types of assistance requested, any actions taken and the disposition of each such matter.

7. Upon request, assist covered employees in using the procedures and processes available to them from their health plan, including all appeal procedures. Such assistance may require the review of health care records of a covered employee, which shall be done only with that employee's express written consent. The confidentiality of any such medical records shall be maintained in accordance with the confidentiality and disclosure laws of the Commonwealth.

8. Ensure that covered employees have access to the services provided by the Ombudsman and that the covered employees receive timely responses from the Ombudsman or his representatives to the inquiries.

9. Report annually on his activities to the standing committees of the General Assembly having jurisdiction over insurance and over health and the Joint Commission on Health Care by December 1 of each year.

M. The plan established in accordance with this section shall not refuse to accept or make reimbursement pursuant to an assignment of benefits made to a dentist or oral surgeon by a covered employee.

For purposes of this subsection, "assignment of benefits" means the transfer of dental care coverage reimbursement benefits or other rights under the plan. The assignment of benefits shall not be effective until the covered employee notifies the plan in writing of the assignment.

N. Beginning July 1, 2006, any plan established pursuant to this section shall provide for an identification number, which shall be assigned to the covered employee and shall not be the same as the employee's social security number.

O. Any group health insurance plan established by the Department of Human Resource Management that contains a coordination of benefits provision shall provide written notification to any eligible employee as a prominent part of its enrollment materials that if such eligible employee is covered under another group accident and sickness insurance policy, group accident and sickness subscription contract, or group health care plan for health care services, that insurance policy, subscription contract or health care plan may have primary responsibility for the covered expenses of other family members enrolled with the eligible employee. Such written notification shall describe generally the conditions upon which the other coverage would be primary for dependent children enrolled under the eligible employee's coverage and the method by which the eligible enrollee may verify from the plan that coverage would have primary responsibility for the covered expenses of each family member.

P. Any plan established by the Department of Human Resource Management pursuant to this section shall provide that coverage under such plan for family members enrolled under a participating state employee's coverage shall continue for a period of at least 30 days following the death of such state employee.

Q. The plan established in accordance with this section that follows a policy of sending its payment to the covered employee or covered family member for a claim for services received from a nonparticipating physician or osteopath shall (i) include language in the member handbook that notifies the covered employee of the responsibility to apply the plan payment to the claim from such nonparticipating provider, (ii) include this language with any such payment sent to the covered employee or covered family member, and (iii) include the name and any last known address of the nonparticipating provider on the explanation of benefits statement.

R. The Department of Human Resource Management shall report annually, by November 30 of each year in which a mandate is imposed under the provisions of § 2.2-2818.2, to the Special Advisory Commission on Mandated Health Insurance Benefits established pursuant to Article 2 (§ 2.2-2503 et seq.) of Chapter 25, on cost and utilization information for each of the mandated benefits set forth in subsection B, including any mandated benefit made applicable, pursuant to subdivision B 22, to any plan established pursuant to this section. The report shall be in the same detail and form as required of reports submitted pursuant to § 38.2-3419.1, with such additional information as is required to determine the financial impact, including the costs and benefits, of the particular mandated benefit.

§ 2.2-2905. Certain officers and employees exempt from chapter.

The provisions of this chapter shall not apply to:

1. Officers and employees for whom the Constitution specifically directs the manner of selection;

2. Officers and employees of the Supreme Court and the Court of Appeals;

3. Officers appointed by the Governor, whether confirmation by the General Assembly or by either house thereof is required or not;

4. Officers elected by popular vote or by the General Assembly or either house thereof;

5. Members of boards and commissions however selected;

6. Judges, referees, receivers, arbiters, masters and commissioners in chancery, commissioners of accounts, and any other persons appointed by any court to exercise judicial functions, and jurors and notaries public;

7. Officers and employees of the General Assembly and persons employed to conduct temporary or special inquiries, investigations, or examinations on its behalf;

8. The presidents, and teaching and research staffs of state educational institutions;

9. Commissioned officers and enlisted personnel of the National Guard and the naval militia;

10. Student employees in institutions of learning, and patient or inmate help in other state institutions;

11. Upon general or special authorization of the Governor, laborers, temporary employees and employees compensated on an hourly or daily basis;

12. County, city, town and district officers, deputies, assistants and employees;

13. The employees of the Virginia Workers' Compensation Commission;

14. The officers and employees of the Virginia Retirement System;

15. Employees whose positions are identified by the State Council of Higher Education and the boards of the Virginia Museum of Fine Arts, The Science Museum of Virginia, the Jamestown-Yorktown Foundation, the Frontier Culture Museum of Virginia, the Virginia Museum of Natural History, the New College Institute, the Southern Virginia Higher Education Center, and The Library of Virginia, and approved by the Director of the Department of Human Resource Management as requiring specialized and professional training;

16. Employees of the State Lottery Department;

17. Production workers for the Virginia Industries for the Blind Sheltered Workshop programs;

18. Employees of the Virginia Commonwealth University Health System Authority;

19. Employees of the University of Virginia Medical Center. Any changes in compensation plans for such employees shall be subject to the review and approval of the Board of Visitors of the University of Virginia. The University of Virginia shall ensure that its procedures for hiring University of Virginia Medical Center personnel are based on merit and fitness. Such employees shall remain subject to the provisions of the State Grievance Procedure (§ 2.2-3000 et seq.);

20. In executive branch agencies the employee who has accepted serving in the capacity of chief deputy, or equivalent, and the employee who has accepted serving in the capacity of a confidential assistant for policy or administration. An employee serving in either one of these two positions shall be deemed to serve on an employment-at-will basis. An agency may not exceed two employees who serve in this exempt capacity;

21. Employees of Virginia Correctional Enterprises. Such employees shall remain subject to the provisions of the State Grievance Procedure (§ 2.2-3000 et seq.);

22. Officers and employees of the Virginia Port Authority;

23. Employees of the Virginia College Savings Plan;

24. Directors of state facilities operated by the Department of Behavioral Health and Developmental Services employed or reemployed by the Commissioner after July 1, 1999, under a contract pursuant to § 37.2-707. Such employees shall remain subject to the provisions of the State Grievance Procedure (§ 2.2-3000 et seq.);

25. The Director of the Virginia Office for Protection and Advocacy;

26. Employees of the Virginia Foundation for Healthy Youth. Such employees shall be treated as state employees for purposes of participation in the Virginia Retirement System, health insurance, and all other employee benefits offered by the Commonwealth to its classified employees;

27. Employees of the Virginia Indigent Defense Commission; ~~and~~

28. Any chief of a campus police department that has been designated by the governing body of a public institution of higher education as exempt, pursuant to § 23-232*; and*

29. Employees of the Virginia Health Benefit Exchange.

§ 2.2-3705.7. Exclusions to application of chapter; records of specific public bodies and certain other limited exemptions.

The following records are excluded from the provisions of this chapter but may be disclosed by the custodian in his discretion, except where such disclosure is prohibited by law:

1. State income, business, and estate tax returns, personal property tax returns, scholastic and confidential records held pursuant to § 58.1-3.

2. Working papers and correspondence of the Office of the Governor; Lieutenant Governor; the Attorney General; the members of the General Assembly, the Division of Legislative Services, or the

Clerks of the House of Delegates and the Senate of Virginia; the mayor or chief executive officer of any political subdivision of the Commonwealth; or the president or other chief executive officer of any public institution of higher education in Virginia. However, no record, which is otherwise open to inspection under this chapter, shall be deemed exempt by virtue of the fact that it has been attached to or incorporated within any working paper or correspondence.

As used in this subdivision:

"Office of the Governor" means the Governor; his chief of staff, counsel, director of policy, Cabinet Secretaries, and the Assistant to the Governor for Intergovernmental Affairs; and those individuals to whom the Governor has delegated his authority pursuant to § 2.2-104.

"Working papers" means those records prepared by or for an above-named public official for his personal or deliberative use.

3. Library records that can be used to identify both (i) any library patron who has borrowed material from a library and (ii) the material such patron borrowed.

4. Contract cost estimates prepared for the confidential use of the Department of Transportation in awarding contracts for construction or the purchase of goods or services, and records and automated systems prepared for the Department's Bid Analysis and Monitoring Program.

5. Lists of registered owners of bonds issued by a political subdivision of the Commonwealth, whether the lists are maintained by the political subdivision itself or by a single fiduciary designated by the political subdivision.

6. Records and writings furnished by a member of the General Assembly to a meeting of a standing committee, special committee or subcommittee of his house established solely for the purpose of reviewing members' annual disclosure statements and supporting materials filed under § 30-110 or of formulating advisory opinions to members on standards of conduct, or both.

7. Customer account information of a public utility affiliated with a political subdivision of the Commonwealth, including the customer's name and service address, but excluding the amount of utility service provided and the amount of money paid for such utility service.

8. Personal information, as defined in § 2.2-3801, (i) filed with the Virginia Housing Development Authority concerning individuals who have applied for or received loans or other housing assistance or who have applied for occupancy of or have occupied housing financed, owned or otherwise assisted by the Virginia Housing Development Authority; (ii) concerning persons participating in or persons on the waiting list for federally funded rent-assistance programs; (iii) filed with any local redevelopment and housing authority created pursuant to § 36-4 concerning persons participating in or persons on the waiting list for housing assistance programs funded by local governments or by any such authority; or (iv) filed with any local redevelopment and housing authority created pursuant to § 36-4 or any other local government agency concerning persons who have applied for occupancy or who have occupied affordable dwelling units established pursuant to § 15.2-2304 or 15.2-2305. However, access to one's own information shall not be denied.

9. Records regarding the siting of hazardous waste facilities, except as provided in § 10.1-1441, if disclosure of them would have a detrimental effect upon the negotiating position of a governing body or on the establishment of the terms, conditions and provisions of the siting agreement.

10. Records containing information on the site specific location of rare, threatened, endangered or otherwise imperiled plant and animal species, natural communities, caves, and significant historic and archaeological sites if, in the opinion of the public body that has the responsibility for such information, disclosure of the information would jeopardize the continued existence or the integrity of the resource. This exemption shall not apply to requests from the owner of the land upon which the resource is located.

11. Records, memoranda, working papers, graphics, video or audio tapes, production models, data and information of a proprietary nature produced by or for or collected by or for the State Lottery Department relating to matters of a specific lottery game design, development, production, operation, ticket price, prize structure, manner of selecting the winning ticket, manner of payment of prizes to holders of winning tickets, frequency of drawings or selections of winning tickets, odds of winning, advertising, or marketing, where such official records have not been publicly released, published, copyrighted or patented. Whether released, published or copyrighted, all game-related information shall be subject to public disclosure under this chapter upon the first day of sales for the specific lottery game to which it pertains.

12. Records of the Virginia Retirement System, acting pursuant to § 51.1-124.30, or of a local retirement system, acting pursuant to § 51.1-803, or of the Rector and Visitors of the University of Virginia, acting pursuant to § 23-76.1, or of the Virginia College Savings Plan, acting pursuant to § 23-38.77, relating to the acquisition, holding or disposition of a security or other ownership interest in an entity, where such security or ownership interest is not traded on a governmentally regulated securities exchange, to the extent that: (i) such records contain confidential analyses prepared for the

Rector and Visitors of the University of Virginia, prepared by the retirement system or the Virginia College Savings Plan, or provided to the retirement system or the Virginia College Savings Plan under a promise of confidentiality, of the future value of such ownership interest or the future financial performance of the entity; and (ii) disclosure of such confidential analyses would have an adverse effect on the value of the investment to be acquired, held or disposed of by the retirement system, the Rector and Visitors of the University of Virginia, or the Virginia College Savings Plan. Nothing in this subdivision shall be construed to prevent the disclosure of records relating to the identity of any investment held, the amount invested, or the present value of such investment.

13. Names and addresses of subscribers to Virginia Wildlife magazine, published by the Department of Game and Inland Fisheries, provided the individual subscriber has requested in writing that the Department not release such information.

14. Financial, medical, rehabilitative and other personal information concerning applicants for or recipients of loan funds submitted to or maintained by the Assistive Technology Loan Fund Authority under Chapter 11 (§ 51.5-53 et seq.) of Title 51.5.

15. Records of the Virginia Commonwealth University Health System Authority pertaining to any of the following: an individual's qualifications for or continued membership on its medical or teaching staffs; proprietary information gathered by or in the possession of the Authority from third parties pursuant to a promise of confidentiality; contract cost estimates prepared for confidential use in awarding contracts for construction or the purchase of goods or services; data, records or information of a proprietary nature produced or collected by or for the Authority or members of its medical or teaching staffs; financial statements not publicly available that may be filed with the Authority from third parties; the identity, accounts or account status of any customer of the Authority; consulting or other reports paid for by the Authority to assist the Authority in connection with its strategic planning and goals; the determination of marketing and operational strategies where disclosure of such strategies would be harmful to the competitive position of the Authority; and data, records or information of a proprietary nature produced or collected by or for employees of the Authority, other than the Authority's financial or administrative records, in the conduct of or as a result of study or research on medical, scientific, technical or scholarly issues, whether sponsored by the Authority alone or in conjunction with a governmental body or a private concern, when such data, records or information have not been publicly released, published, copyrighted or patented.

16. Records of the Department of Environmental Quality, the State Water Control Board, State Air Pollution Control Board or the Virginia Waste Management Board relating to (i) active federal environmental enforcement actions that are considered confidential under federal law and (ii) enforcement strategies, including proposed sanctions for enforcement actions. Upon request, such records shall be disclosed after a proposed sanction resulting from the investigation has been proposed to the director of the agency. This subdivision shall not be construed to prohibit the disclosure of records related to inspection reports, notices of violation, and documents detailing the nature of any environmental contamination that may have occurred or similar documents.

17. As it pertains to any person, records related to the operation of toll facilities that identify an individual, vehicle, or travel itinerary including, but not limited to, vehicle identification data, vehicle enforcement system information; video or photographic images; Social Security or other identification numbers appearing on driver's licenses; credit card or bank account data; home addresses; phone numbers; or records of the date or time of toll facility use.

18. Records of the State Lottery Department pertaining to (i) the social security number, tax identification number, state sales tax number, home address and telephone number, personal and lottery banking account and transit numbers of a retailer, and financial information regarding the nonlottery operations of specific retail locations; and (ii) individual lottery winners, except that a winner's name, hometown, and amount won shall be disclosed.

19. Records of the Board for Branch Pilots relating to the chemical or drug testing of a person regulated by the Board, where such person has tested negative or has not been the subject of a disciplinary action by the Board for a positive test result.

20. Records, investigative notes, correspondence, and information pertaining to the planning, scheduling and performance of examinations of holder records pursuant to the Uniform Disposition of Unclaimed Property Act (§ 55-210.1 et seq.) prepared by or for the State Treasurer, his agents, employees or persons employed to perform an audit or examination of holder records.

21. Records of the Virginia Department of Emergency Management or a local governing body relating to citizen emergency response teams established pursuant to an ordinance of a local governing body, to the extent that such records reveal the name, address, including e-mail address, telephone or pager numbers, or operating schedule of an individual participant in the program.

22. Records of state or local park and recreation departments and local and regional park authorities to the extent such records contain information identifying a person under the age of 18 years, where the parent or legal guardian of such person has requested in writing that such information not be disclosed.

However, nothing in this subdivision shall operate to prohibit the disclosure of information defined as directory information under regulations implementing the Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g, unless the public body has undertaken the parental notification and opt-out requirements provided by such regulations. Access shall not be denied to the parent, including a noncustodial parent, or guardian of such person, unless the parent's parental rights have been terminated or a court of competent jurisdiction has restricted or denied such access. For records of such persons who are emancipated, the right of access may be asserted by the subject thereof.

23. Records submitted for inclusion in the Statewide Alert Network administered by the Department of Emergency Management, to the extent that they reveal names, physical addresses, email addresses, computer or internet protocol information, telephone numbers, pager numbers, other wireless or portable communications device information, or operating schedules of individuals or agencies, where the release of such information would compromise the security of the Statewide Alert Network or individuals participating in the Statewide Alert Network.

24. Records of the Judicial Inquiry and Review Commission made confidential by § 17.1-913.

25. Records of the Virginia Retirement System acting pursuant to § 51.1-124.30, of a local retirement system acting pursuant to § 51.1-803 (hereinafter collectively referred to as the retirement system), or of the Virginia College Savings Plan, acting pursuant to § 23-38.77 relating to:

a. Internal deliberations of or decisions by the retirement system or the Virginia College Savings Plan on the pursuit of particular investment strategies, or the selection or termination of investment managers, prior to the execution of such investment strategies or the selection or termination of such managers, to the extent that disclosure of such records would have an adverse impact on the financial interest of the retirement system or the Virginia College Savings Plan; and

b. Trade secrets, as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.), provided by a private entity to the retirement system or the Virginia College Savings Plan, to the extent disclosure of such records would have an adverse impact on the financial interest of the retirement system or the Virginia College Savings Plan.

For the records specified in subdivision b to be excluded from the provisions of this chapter, the entity shall make a written request to the retirement system or the Virginia College Savings Plan:

(1) Invoking such exclusion prior to or upon submission of the data or other materials for which protection from disclosure is sought;

(2) Identifying with specificity the data or other materials for which protection is sought; and

(3) Stating the reasons why protection is necessary.

The retirement system or the Virginia College Savings Plan shall determine whether the requested exclusion from disclosure meets the requirements set forth in subdivision b.

Nothing in this subdivision shall be construed to authorize the withholding of the identity or amount of any investment held or the present value and performance of all asset classes and subclasses.

26. Records of the Department of Corrections made confidential by § 53.1-233.

27. Records maintained by the Department of the Treasury or participants in the Local Government Investment Pool (§ 2.2-4600 et seq.), to the extent such records relate to information required to be provided by such participants to the Department to establish accounts in accordance with § 2.2-4602.

28. Personal information, as defined in § 2.2-3801, contained in the Veterans Care Center Resident Trust Funds concerning residents or patients of the Department of Veterans Services Care Centers, except that access shall not be denied to the person who is the subject of the record.

29. Records maintained in connection with fundraising activities by the Veterans Services Foundation pursuant to § 2.2-2716 to the extent that such records reveal the address, electronic mail address, facsimile or telephone number, social security number or other identification number appearing on a driver's license, or credit card or bank account data of identifiable donors, except that access shall not be denied to the person who is the subject of the record. Nothing in this subdivision, however, shall be construed to authorize the withholding of records relating to the amount, date, purpose, and terms of the pledge or donation or the identity of the donor. The exclusion provided by this subdivision shall not apply to protect from disclosure (i) the identities of sponsors providing grants to or contracting with the foundation for the performance of services or other work or (ii) the terms and conditions of such grants or contracts.

30. Records of the Virginia Health Benefit Exchange Authority pertaining to the names and applications of individuals and employers seeking coverage through the Virginia Exchange; individuals' health information; information exchanged between the Virginia Exchange and the Department of Social Services, Department of Taxation, State Corporation Commission, or any other state agency that is subject to confidentiality agreements under contracts entered into with the Authority; and proprietary information gathered by or in the possession of the Authority from third parties pursuant to a promise of confidentiality.

§ 2.2-3711. Closed meetings authorized for certain limited purposes.

A. Public bodies may hold closed meetings only for the following purposes:

1. Discussion, consideration, or interviews of prospective candidates for employment; assignment, appointment, promotion, performance, demotion, salaries, disciplining, or resignation of specific public officers, appointees, or employees of any public body; and evaluation of performance of departments or schools of public institutions of higher education where such evaluation will necessarily involve discussion of the performance of specific individuals. Any teacher shall be permitted to be present during a closed meeting in which there is a discussion or consideration of a disciplinary matter that involves the teacher and some student and the student involved in the matter is present, provided the teacher makes a written request to be present to the presiding officer of the appropriate board.

2. Discussion or consideration of admission or disciplinary matters or any other matters that would involve the disclosure of information contained in a scholastic record concerning any student of any Virginia public institution of higher education or any state school system. However, any such student, legal counsel and, if the student is a minor, the student's parents or legal guardians shall be permitted to be present during the taking of testimony or presentation of evidence at a closed meeting, if such student, parents, or guardians so request in writing and such request is submitted to the presiding officer of the appropriate board.

3. Discussion or consideration of the acquisition of real property for a public purpose, or of the disposition of publicly held real property, where discussion in an open meeting would adversely affect the bargaining position or negotiating strategy of the public body.

4. The protection of the privacy of individuals in personal matters not related to public business.

5. Discussion concerning a prospective business or industry or the expansion of an existing business or industry where no previous announcement has been made of the business' or industry's interest in locating or expanding its facilities in the community.

6. Discussion or consideration of the investment of public funds where competition or bargaining is involved, where, if made public initially, the financial interest of the governmental unit would be adversely affected.

7. Consultation with legal counsel and briefings by staff members or consultants pertaining to actual or probable litigation, where such consultation or briefing in open meeting would adversely affect the negotiating or litigating posture of the public body; and consultation with legal counsel employed or retained by a public body regarding specific legal matters requiring the provision of legal advice by such counsel. For the purposes of this subdivision, "probable litigation" means litigation that has been specifically threatened or on which the public body or its legal counsel has a reasonable basis to believe will be commenced by or against a known party. Nothing in this subdivision shall be construed to permit the closure of a meeting merely because an attorney representing the public body is in attendance or is consulted on a matter.

8. In the case of boards of visitors of public institutions of higher education, discussion or consideration of matters relating to gifts, bequests and fund-raising activities, and grants and contracts for services or work to be performed by such institution. However, the terms and conditions of any such gifts, bequests, grants, and contracts made by a foreign government, a foreign legal entity, or a foreign person and accepted by a public institution of higher education in Virginia shall be subject to public disclosure upon written request to the appropriate board of visitors. For the purpose of this subdivision, (i) "foreign government" means any government other than the United States government or the government of a state or a political subdivision thereof; (ii) "foreign legal entity" means any legal entity created under the laws of the United States or of any state thereof if a majority of the ownership of the stock of such legal entity is owned by foreign governments or foreign persons or if a majority of the membership of any such entity is composed of foreign persons or foreign legal entities, or any legal entity created under the laws of a foreign government; and (iii) "foreign person" means any individual who is not a citizen or national of the United States or a trust territory or protectorate thereof.

9. In the case of the boards of trustees of the Virginia Museum of Fine Arts, the Virginia Museum of Natural History, and The Science Museum of Virginia, discussion or consideration of matters relating to specific gifts, bequests, and grants.

10. Discussion or consideration of honorary degrees or special awards.

11. Discussion or consideration of tests, examinations, or other records excluded from this chapter pursuant to subdivision 4 of § 2.2-3705.1.

12. Discussion, consideration, or review by the appropriate House or Senate committees of possible disciplinary action against a member arising out of the possible inadequacy of the disclosure statement filed by the member, provided the member may request in writing that the committee meeting not be conducted in a closed meeting.

13. Discussion of strategy with respect to the negotiation of a hazardous waste siting agreement or to consider the terms, conditions, and provisions of a hazardous waste siting agreement if the governing body in open meeting finds that an open meeting will have an adverse effect upon the negotiating position of the governing body or the establishment of the terms, conditions and provisions of the siting

agreement, or both. All discussions with the applicant or its representatives may be conducted in a closed meeting.

14. Discussion by the Governor and any economic advisory board reviewing forecasts of economic activity and estimating general and nongeneral fund revenues.

15. Discussion or consideration of medical and mental records excluded from this chapter pursuant to subdivision 1 of § 2.2-3705.5.

16. Deliberations of the State Lottery Board in a licensing appeal action conducted pursuant to subsection D of § 58.1-4007 regarding the denial or revocation of a license of a lottery sales agent; and discussion, consideration or review of State Lottery Department matters related to proprietary lottery game information and studies or investigations exempted from disclosure under subdivision 6 of § 2.2-3705.3 and subdivision 11 of § 2.2-3705.7.

17. Those portions of meetings by local government crime commissions where the identity of, or information tending to identify, individuals providing information about crimes or criminal activities under a promise of anonymity is discussed or disclosed.

18. Those portions of meetings in which the Board of Corrections discusses or discloses the identity of, or information tending to identify, any prisoner who (i) provides information about crimes or criminal activities, (ii) renders assistance in preventing the escape of another prisoner or in the apprehension of an escaped prisoner, or (iii) voluntarily or at the instance of a prison official renders other extraordinary services, the disclosure of which is likely to jeopardize the prisoner's life or safety.

19. Discussion of plans to protect public safety as it relates to terrorist activity and briefings by staff members, legal counsel, or law-enforcement or emergency service officials concerning actions taken to respond to such activity or a related threat to public safety; or discussion of reports or plans related to the security of any governmental facility, building or structure, or the safety of persons using such facility, building or structure.

20. Discussion by the Board of the Virginia Retirement System, acting pursuant to § 51.1-124.30, or of any local retirement system, acting pursuant to § 51.1-803, or of the Rector and Visitors of the University of Virginia, acting pursuant to § 23-76.1, or by the Board of the Virginia College Savings Plan, acting pursuant to § 23-38.80, regarding the acquisition, holding or disposition of a security or other ownership interest in an entity, where such security or ownership interest is not traded on a governmentally regulated securities exchange, to the extent that such discussion (i) concerns confidential analyses prepared for the Rector and Visitors of the University of Virginia, prepared by the retirement system or by the Virginia College Savings Plan or provided to the retirement system or the Virginia College Savings Plan under a promise of confidentiality, of the future value of such ownership interest or the future financial performance of the entity, and (ii) would have an adverse effect on the value of the investment to be acquired, held or disposed of by the retirement system, the Rector and Visitors of the University of Virginia, or the Virginia College Savings Plan. Nothing in this subdivision shall be construed to prevent the disclosure of information relating to the identity of any investment held, the amount invested or the present value of such investment.

21. Those portions of meetings in which individual child death cases are discussed by the State Child Fatality Review team established pursuant to § 32.1-283.1, and those portions of meetings in which individual child death cases are discussed by a regional or local child fatality review team established pursuant to § 32.1-283.2, and those portions of meetings in which individual death cases are discussed by family violence fatality review teams established pursuant to § 32.1-283.3.

22. Those portions of meetings of the University of Virginia Board of Visitors or the Eastern Virginia Medical School Board of Visitors, as the case may be, and those portions of meetings of any persons to whom management responsibilities for the University of Virginia Medical Center or Eastern Virginia Medical School, as the case may be, have been delegated, in which there is discussed proprietary, business-related information pertaining to the operations of the University of Virginia Medical Center or Eastern Virginia Medical School, as the case may be, including business development or marketing strategies and activities with existing or future joint venturers, partners, or other parties with whom the University of Virginia Medical Center or Eastern Virginia Medical School, as the case may be, has formed, or forms, any arrangement for the delivery of health care, if disclosure of such information would adversely affect the competitive position of the Medical Center or Eastern Virginia Medical School, as the case may be.

23. In the case of the Virginia Commonwealth University Health System Authority, discussion or consideration of any of the following: the acquisition or disposition of real or personal property where disclosure would adversely affect the bargaining position or negotiating strategy of the Authority; operational plans that could affect the value of such property, real or personal, owned or desirable for ownership by the Authority; matters relating to gifts, bequests and fund-raising activities; grants and contracts for services or work to be performed by the Authority; marketing or operational strategies where disclosure of such strategies would adversely affect the competitive position of the Authority;

members of its medical and teaching staffs and qualifications for appointments thereto; and qualifications or evaluations of other employees.

24. Those portions of the meetings of the Health Practitioners' Monitoring Program Committee within the Department of Health Professions to the extent such discussions identify any practitioner who may be, or who actually is, impaired pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of Title 54.1.

25. Meetings or portions of meetings of the Board of the Virginia College Savings Plan wherein personal information, as defined in § 2.2-3801, which has been provided to the Board or its employees by or on behalf of individuals who have requested information about, applied for, or entered into prepaid tuition contracts or savings trust account agreements pursuant to Chapter 4.9 (§ 23-38.75 et seq.) of Title 23 is discussed.

26. Discussion or consideration, by the Wireless Carrier E-911 Cost Recovery Subcommittee created pursuant to § 56-484.15, of trade secrets, as defined in the Uniform Trade Secrets Act (§ 59.1-336 et seq.), submitted by CMRS providers as defined in § 56-484.12, related to the provision of wireless E-911 service.

27. Those portions of disciplinary proceedings by any regulatory board within the Department of Professional and Occupational Regulation, Department of Health Professions, or the Board of Accountancy conducted pursuant to § 2.2-4019 or 2.2-4020 during which the board deliberates to reach a decision or meetings of health regulatory boards or conference committees of such boards to consider settlement proposals in pending disciplinary actions or modifications to previously issued board orders as requested by either of the parties.

28. Discussion or consideration of records excluded from this chapter pursuant to subdivision 11 of § 2.2-3705.6 by a responsible public entity or an affected local jurisdiction, as those terms are defined in § 56-557, or any independent review panel appointed to review information and advise the responsible public entity concerning such records.

29. Discussion of the award of a public contract involving the expenditure of public funds, including interviews of bidders or offerors, and discussion of the terms or scope of such contract, where discussion in an open session would adversely affect the bargaining position or negotiating strategy of the public body.

30. Discussion or consideration of grant or loan application records excluded from this chapter pursuant to subdivision 17 of § 2.2-3705.6 by (i) the Commonwealth Health Research Board or (ii) the Innovation and Entrepreneurship Investment Authority or the Research and Technology Investment Advisory Committee appointed to advise the Innovation and Entrepreneurship Investment Authority.

31. Discussion or consideration by the Commitment Review Committee of records excluded from this chapter pursuant to subdivision 9 of § 2.2-3705.2 relating to individuals subject to commitment as sexually violent predators under Chapter 9 (§ 37.2-900 et seq.) of Title 37.2.

32. [Expired.]

33. Discussion or consideration of confidential proprietary records and trade secrets excluded from this chapter pursuant to subdivision 18 of § 2.2-3705.6.

34. Discussion or consideration by a local authority created in accordance with the Virginia Wireless Service Authorities Act (§ 15.2-5431.1 et seq.) of confidential proprietary records and trade secrets excluded from this chapter pursuant to subdivision 19 of § 2.2-3705.6.

35. Discussion or consideration by the State Board of Elections or local electoral boards of voting security matters made confidential pursuant to § 24.2-625.1.

36. Discussion or consideration by the Forensic Science Board or the Scientific Advisory Committee created pursuant to Article 2 (§ 9.1-1109 et seq.) of Chapter 11 of Title 9.1 of records excluded from this chapter pursuant to subdivision F 1 of § 2.2-3706.

37. Discussion or consideration by the Brown v. Board of Education Scholarship Program Awards Committee of records or confidential matters excluded from this chapter pursuant to subdivision 3 of § 2.2-3705.4, and meetings of the Committee to deliberate concerning the annual maximum scholarship award, review and consider scholarship applications and requests for scholarship award renewal, and cancel, rescind, or recover scholarship awards.

38. Discussion or consideration by the Virginia Port Authority of records excluded from this chapter pursuant to subdivision 1 of § 2.2-3705.6.

39. Discussion or consideration by the Board of Trustees of the Virginia Retirement System acting pursuant to § 51.1-124.30, by the Investment Advisory Committee appointed pursuant to § 51.1-124.26, by any local retirement system, acting pursuant to § 51.1-803, by the Board of the Virginia College Savings Plan acting pursuant to § 23-38.80, or by the Virginia College Savings Plan's Investment Advisory Committee appointed pursuant to § 23-38.79:1 of records excluded from this chapter pursuant to subdivision 25 of § 2.2-3705.7.

40. Discussion or consideration of records excluded from this chapter pursuant to subdivision 3 of § 2.2-3705.6.

41. Discussion or consideration by the Board of Education of records relating to the denial,

suspension, or revocation of teacher licenses excluded from this chapter pursuant to subdivision 13 of § 2.2-3705.3.

42. Those portions of meetings of the Virginia Military Advisory Council, the Virginia National Defense Industrial Authority, any commission created by executive order for the purpose of studying and making recommendations regarding preventing closure or realignment of federal military and national security installations and facilities located in Virginia and relocation of such facilities to Virginia, or a local or regional military affairs organization appointed by a local governing body, during which there is discussion of records excluded from this chapter pursuant to subdivision 12 of § 2.2-3705.2.

43. Discussion or consideration by the Board of Trustees of the Veterans Services Foundation of records excluded from this chapter pursuant to subdivision 29 of § 2.2-3705.7.

44. Discussion or consideration by the Virginia Tobacco Indemnification and Community Revitalization Commission of records excluded from this chapter pursuant to subdivision 23 of § 2.2-3705.6.

45. Discussion or consideration by the board of directors of the Commercial Space Flight Authority of records excluded from this chapter pursuant to subdivision 24 of § 2.2-3705.6.

46. Discussion or consideration by the board of directors of the Virginia Health Benefit Exchange Authority of records exempted from disclosure under subdivision 30 of § 2.2-3705.7.

B. No resolution, ordinance, rule, contract, regulation or motion adopted, passed or agreed to in a closed meeting shall become effective unless the public body, following the meeting, reconvenes in open meeting and takes a vote of the membership on such resolution, ordinance, rule, contract, regulation, or motion that shall have its substance reasonably identified in the open meeting.

C. Public officers improperly selected due to the failure of the public body to comply with the other provisions of this section shall be de facto officers and, as such, their official actions are valid until they obtain notice of the legal defect in their election.

D. Nothing in this section shall be construed to prevent the holding of conferences between two or more public bodies, or their representatives, but these conferences shall be subject to the same procedures for holding closed meetings as are applicable to any other public body.

E. This section shall not be construed to (i) require the disclosure of any contract between the Department of Health Professions and an impaired practitioner entered into pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of Title 54.1 or (ii) require the board of directors of any authority created pursuant to the Industrial Development and Revenue Bond Act (§ 15.2-4900 et seq.), or any public body empowered to issue industrial revenue bonds by general or special law, to identify a business or industry to which subdivision A 5 applies. However, such business or industry shall be identified as a matter of public record at least 30 days prior to the actual date of the board's authorization of the sale or issuance of such bonds.

§ 2.2-4002. Exemptions from chapter generally.

A. Although required to comply with § 2.2-4103 of the Virginia Register Act (§ 2.2-4100 et seq.), the following agencies shall be exempted from the provisions of this chapter, except to the extent that they are specifically made subject to §§ 2.2-4024, 2.2-4030 and 2.2-4031:

1. The General Assembly.

2. Courts, any agency of the Supreme Court, and any agency that by the Constitution is expressly granted any of the powers of a court of record.

3. The Department of Game and Inland Fisheries in promulgating regulations regarding the management of wildlife and for all case decisions rendered pursuant to any provisions of Chapters 2 (§ 29.1-200 et seq.), 3 (§ 29.1-300 et seq.), 4 (§ 29.1-400 et seq.), 5 (§ 29.1-500 et seq.), and 7 (§ 29.1-700 et seq.) of Title 29.1.

4. The Virginia Housing Development Authority.

5. Municipal corporations, counties, and all local, regional or multijurisdictional authorities created under this Code, including those with federal authorities.

6. Educational institutions operated by the Commonwealth, provided that, with respect to § 2.2-4031, such educational institutions shall be exempt from the publication requirements only with respect to regulations that pertain to (i) their academic affairs, (ii) the selection, tenure, promotion and disciplining of faculty and employees, (iii) the selection of students, and (iv) rules of conduct and disciplining of students.

7. The Milk Commission in promulgating regulations regarding (i) producers' licenses and bases, (ii) classification and allocation of milk, computation of sales and shrinkage, and (iii) class prices for producers' milk, time and method of payment, butterfat testing and differential.

8. The Virginia Resources Authority.

9. Agencies expressly exempted by any other provision of this Code.

10. The Department of General Services in promulgating standards for the inspection of buildings for

asbestos pursuant to § 2.2-1164.

11. The State Council of Higher Education for Virginia, in developing, issuing, and revising guidelines pursuant to § 23-9.6:2.

12. The Commissioner of Agriculture and Consumer Services in adopting regulations pursuant to subsection B of § 3.2-6002 and in adopting regulations pursuant to § 3.2-6023.

13. The Commissioner of Agriculture and Consumer Services and the Board of Agriculture and Consumer Services in promulgating regulations pursuant to subsections B and D of § 3.2-3601, subsection B of § 3.2-3701, § 3.2-4002, subsections B and D of § 3.2-4801, §§ 3.2-5121 and 3.2-5206, and subsection A of § 3.2-5406.

14. The Board of Optometry when specifying therapeutic pharmaceutical agents, treatment guidelines, and diseases and abnormal conditions of the human eye and its adnexa for TPA-certification of optometrists pursuant to Article 5 (§ 54.1-3222 et seq.) of Chapter 32 of Title 54.1.

15. The Virginia War Memorial Foundation.

16. The State Board of Education, in developing, issuing, and revising guidelines pursuant to § 22.1-203.2.

17. The Virginia Racing Commission, (i) when acting by and through its duly appointed stewards or in matters related to any specific race meeting or (ii) in promulgating technical rules regulating actual live horse racing at race meetings licensed by the Commission.

18. The Virginia Small Business Financing Authority.

19. The Virginia Economic Development Partnership Authority.

20. The Board of Agriculture and Consumer Services in adopting, amending or repealing regulations pursuant to subsection A (ii) of § 59.1-156.

21. The Insurance Continuing Education Board pursuant to § 38.2-1867.

22. The Board of Health in promulgating the list of diseases that shall be reported to the Department of Health pursuant to § 32.1-35 and in adopting, amending or repealing regulations pursuant to subsection C of § 35.1-14 that incorporate the Food and Drug Administration's Food Code pertaining to restaurants or food service.

23. (Expires January 1, 2014) The Secretary of Natural Resources in setting a date of closure for the Chesapeake Bay purse seine fishery for Atlantic menhaden for reduction purposes pursuant to § 28.2-1000.2.

24. The Board of Pharmacy when specifying special subject requirements for continuing education for pharmacists pursuant to § 54.1-3314.1.

25. The Virginia Health Benefit Exchange Authority.

B. Agency action relating to the following subjects shall be exempted from the provisions of this chapter:

1. Money or damage claims against the Commonwealth or agencies thereof.

2. The award or denial of state contracts, as well as decisions regarding compliance therewith.

3. The location, design, specifications or construction of public buildings or other facilities.

4. Grants of state or federal funds or property.

5. The chartering of corporations.

6. Customary military, militia, naval or police functions.

7. The selection, tenure, dismissal, direction or control of any officer or employee of an agency of the Commonwealth.

8. The conduct of elections or eligibility to vote.

9. Inmates of prisons or other such facilities or parolees therefrom.

10. The custody of persons in, or sought to be placed in, mental, penal or other state institutions as well as the treatment, supervision, or discharge of such persons.

11. Traffic signs, markers or control devices.

12. Instructions for application or renewal of a license, certificate, or registration required by law.

13. Content of, or rules for the conduct of, any examination required by law.

14. The administration of pools authorized by Chapter 47 (§ 2.2-4700 et seq.) of this title.

15. Any rules for the conduct of specific lottery games, so long as such rules are not inconsistent with duly adopted regulations of the State Lottery Board, and provided that such regulations are published and posted.

16. Orders condemning or closing any shellfish, finfish, or crustacea growing area and the shellfish, finfish or crustacea located thereon pursuant to Article 2 (§ 28.2-803 et seq.) of Chapter 8 of Title 28.2.

17. Any operating procedures for review of child deaths developed by the State Child Fatality Review Team pursuant to § 32.1-283.1.

18. The regulations for the implementation of the Health Practitioners' Monitoring Program and the activities of the Health Practitioners' Monitoring Program Committee pursuant to Chapter 25.1 (§ 54.1-2515 et seq.) of Title 54.1.

19. The process of reviewing and ranking grant applications submitted to the Commonwealth

Neurotrauma Initiative Advisory Board pursuant to Chapter 3.1 (§ 51.5-12.1 et seq.) of Title 51.5.

20. Loans from the Small Business Environmental Compliance Assistance Fund pursuant to Article 4 (§ 10.1-1197.1 et seq.) of Chapter 11.1 of Title 10.1.

21. The Virginia Breeders Fund created pursuant to § 59.1-372.

22. The types of pari-mutuel wagering pools available for live or simulcast horse racing.

23. The administration of medication or other substances foreign to the natural horse.

C. Minor changes to regulations published in the Virginia Administrative Code under the Virginia Register Act, Chapter 41 (§ 2.2-4100 et seq.) of this title, made by the Virginia Code Commission pursuant to § 30-150, shall be exempt from the provisions of this chapter.

§ 2.2-4343. Exemption from operation of chapter for certain transactions.

A. The provisions of this chapter shall not apply to:

1. The Virginia Port Authority in the exercise of any of its powers in accordance with Chapter 10 (§ 62.1-128 et seq.) of Title 62.1, provided the Authority implements, by policy or regulation adopted by the Board of Commissioners and approved by the Department of General Services, procedures to ensure fairness and competitiveness in the procurement of goods and services and in the administration of its capital outlay program. This exemption shall be applicable only so long as such policies and procedures meeting the requirements remain in effect.

2. The Virginia Retirement System for selection of services related to the management, purchase or sale of authorized investments, actuarial services, and disability determination services. Selection of these services shall be governed by the standard set forth in § 51.1-124.30.

3. The State Treasurer in the selection of investment management services related to the external management of funds shall be governed by the standard set forth in § 2.2-4514, and shall be subject to competitive guidelines and policies that are set by the Commonwealth Treasury Board and approved by the Department of General Services.

4. The Department of Social Services or local departments of social services for the acquisition of motor vehicles for sale or transfer to Temporary Assistance to Needy Families (TANF) recipients.

5. The College of William and Mary in Virginia, Virginia Commonwealth University, the University of Virginia, and Virginia Polytechnic Institute and State University in the selection of services related to the management and investment of their endowment funds, endowment income, gifts, all other nongeneral fund reserves and balances, or local funds of or held by the College or Universities pursuant to § 23-44.1, 23-50.10:01, 23-76.1, or 23-122.1. However, selection of these services shall be governed by the Uniform Prudent Management of Institutional Funds Act (§ 55-268.11 et seq.) as required by §§ 23-44.1, 23-50.10:01, 23-76.1, and 23-122.1.

6. The Board of the Virginia College Savings Plan for the selection of services related to the operation and administration of the Plan, including, but not limited to, contracts or agreements for the management, purchase, or sale of authorized investments or actuarial, record keeping, or consulting services. However, such selection shall be governed by the standard set forth in § 23-38.80.

7. Public institutions of higher education for the purchase of items for resale at retail bookstores and similar retail outlets operated by such institutions. However, such purchase procedures shall provide for competition where practicable.

8. The purchase of goods and services by agencies of the legislative branch that may be specifically exempted therefrom by the Chairman of the Committee on Rules of either the House of Delegates or the Senate. Nor shall the contract review provisions of § 2.2-2011 apply to such procurements. The exemption shall be in writing and kept on file with the agency's disbursement records.

9. Any town with a population of less than 3,500, except as stipulated in the provisions of §§ 2.2-4305, 2.2-4308, 2.2-4311, 2.2-4315, 2.2-4330, 2.2-4333 through 2.2-4338, 2.2-4343.1, and 2.2-4367 through 2.2-4377.

10. Any county, city or town whose governing body has adopted, by ordinance or resolution, alternative policies and procedures which are (i) based on competitive principles and (ii) generally applicable to procurement of goods and services by such governing body and its agencies, except as stipulated in subdivision 12.

This exemption shall be applicable only so long as such policies and procedures, or other policies and procedures meeting the requirements of § 2.2-4300, remain in effect in such county, city or town. Such policies and standards may provide for incentive contracting that offers a contractor whose bid is accepted the opportunity to share in any cost savings realized by the locality when project costs are reduced by such contractor, without affecting project quality, during construction of the project. The fee, if any, charged by the project engineer or architect for determining such cost savings shall be paid as a separate cost and shall not be calculated as part of any cost savings.

11. Any school division whose school board has adopted, by policy or regulation, alternative policies and procedures that are (i) based on competitive principles and (ii) generally applicable to procurement of goods and services by the school board, except as stipulated in subdivision 12.

This exemption shall be applicable only so long as such policies and procedures, or other policies or procedures meeting the requirements of § 2.2-4300, remain in effect in such school division. This provision shall not exempt any school division from any centralized purchasing ordinance duly adopted by a local governing body.

12. Notwithstanding the exemptions set forth in subdivisions 9 through 11, the provisions of subsections C and D of § 2.2-4303, and §§ 2.2-4305, 2.2-4308, 2.2-4311, 2.2-4315, 2.2-4317, 2.2-4330, 2.2-4333 through 2.2-4338, 2.2-4343.1, and 2.2-4367 through 2.2-4377 shall apply to all counties, cities and school divisions, and to all towns having a population greater than 3,500 in the Commonwealth.

The method for procurement of professional services set forth in subdivision 3 a of § 2.2-4301 in the definition of competitive negotiation shall also apply to all counties, cities and school divisions, and to all towns having a population greater than 3,500, where the cost of the professional service is expected to exceed $50,000 in the aggregate or for the sum of all phases of a contract or project. For procurements where the cost of the professional service is not expected to exceed $50,000 in the aggregate or for the sum of all phases of a contract or project, subsection H of § 2.2-4303 shall apply. A school board that makes purchases through its public school foundation or purchases educational technology through its educational technology foundation, either as may be established pursuant to § 22.1-212.2:2 shall be exempt from the provisions of this chapter, except, relative to such purchases, the school board shall comply with the provisions of §§ 2.2-4311 and 2.2-4367 through 2.2-4377.

13. A public body that is also a utility operator may purchase services through or participate in contracts awarded by one or more utility operators that are not public bodies for utility marking services as required by the Underground Utility Damage Prevention Act (§ 56-265.14 et seq.). A purchase of services under this subdivision may deviate from the procurement procedures set forth in this chapter upon a determination made in advance by the public body and set forth in writing that competitive sealed bidding is either not practicable or not fiscally advantageous to the public, and the contract is awarded based on competitive principles.

14. Procurement of any construction or planning and design services for construction by a Virginia nonprofit corporation or organization not otherwise specifically exempted when (i) the planning, design or construction is funded by state appropriations of $10,000 or less or (ii) the Virginia nonprofit corporation or organization is obligated to conform to procurement procedures that are established by federal statutes or regulations, whether those federal procedures are in conformance with the provisions of this chapter.

15. Purchases, exchanges, gifts or sales by the Citizens' Advisory Council on Furnishing and Interpreting the Executive Mansion.

16. The Eastern Virginia Medical School in the selection of services related to the management and investment of its endowment and other institutional funds. The selection of these services shall, however, be governed by the Uniform Prudent Management of Institutional Funds Act (§ 55-268.11 et seq.).

17. The Department of Corrections in the selection of pre-release and post-incarceration services.

18. The Board of the Chippokes Plantation Farm Foundation in entering into agreements with persons for the construction, operation, and maintenance of projects consistent with the Chippokes Plantation State Park Master Plan approved by the Director of the Department of Conservation and Recreation pursuant to the requirements of § 10.1-200.1 and designed to further an appreciation for rural living and the contributions of the agricultural, forestry, and natural resource based industries of the Commonwealth, provided such projects are supported solely by private or nonstate funding.

19. The University of Virginia Medical Center to the extent provided by subdivision B 3 of § 23-77.4.

20. The purchase of goods and services by a local governing body or any authority, board, department, instrumentality, institution, agency or other unit of state government when such purchases are made under a remedial plan established by the Governor pursuant to subsection C of § 2.2-4310 or by a chief administrative officer of a county, city or town pursuant to § 15.2-965.1.

21. The contract by community services boards or behavioral health authorities with an administrator or management body pursuant to a joint agreement authorized by § 37.2-512 or 37.2-615.

22. (Contingent expiration date.) Procurement of any construction or planning and design services and contracts with or assigned to George Mason University by the corporation or other legal entity created by the board of visitors of George Mason University for the establishment and operation of the branch campus of George Mason University in the Republic of Korea, pursuant to § 23-91.29:1.

23. The Virginia Health Benefit Exchange to the extent provided by § 38.2-6421.

B. Where a procurement transaction involves the expenditure of federal assistance or contract funds, the receipt of which is conditioned upon compliance with mandatory requirements in federal laws or regulations not in conformance with the provisions of this chapter, a public body may comply with such federal requirements, notwithstanding the provisions of this chapter, only upon the written determination of the Governor, in the case of state agencies, or the governing body, in the case of political subdivisions, that acceptance of the grant or contract funds under the applicable conditions is in the

public interest. Such determination shall state the specific provision of this chapter in conflict with the conditions of the grant or contract.

§ 32.1-16. State Department of Health.

A. There shall be a State Department of Health in the executive department responsible to the Secretary of Health and Human Resources. The Department shall be under the supervision and management of the State Health Commissioner. The Commissioner shall carry out his management and supervisory responsibilities in accordance with the policies, rules and regulations of the Board.

B. In addition to other duties imposed upon the Department pursuant to this title, the Department shall assist the Virginia Health Benefit Exchange Authority in its implementation of the provisions of Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2 by:

1. Entering into one or more agreements, as described in § 38.2-6417, with the Authority, the State Corporation Commission, the Department of Medical Assistance Services, or the Department of Social Services, which agreements shall provide for compensation of the Department by the Authority for expenses incurred in performing its obligations thereunder;

2. Determining that health plans offered in the Exchange, and health carriers offering such plans, as applicable, (i) provide network adequacy, (ii) comply with requirements regarding minimum geographical area regarding service areas, (iii) have a network that includes essential community providers that serve low-income, underserved communities, (iv) implement quality improvement strategies through market-based incentives, and (v) provide information on quality measures for health plan performance, as provided in §§ 1311(c)(1)(B), 1311(c)(1)(C), 1311(c)(1)(E), and 1311(c)(1)(H) of the Federal Act, as such term is defined in § 38.2-6401; and

3. Performing such other tasks relating to the establishment and operation of the Virginia Exchange as is provided in an agreement entered into pursuant to subdivision 1 or as is required in order to assist the Authority in complying with the applicable requirements of the Federal Act, as such term is defined in § 38.2-6401, that pertain to programs and functions of the Department.

§ 32.1-321.1. Powers and duties of Department.

The Department of Medical Assistance Services shall have the following powers and duties:

1. To investigate and refer for prosecution violations of applicable state and federal laws and regulations pertaining to the application for and receipt of services or benefits;

2. To investigate and refer for civil recovery any debts owed to the medical assistance program or funds paid for services or benefits as a result of violations of applicable state and federal laws and regulations pertaining to the application for and receipt of services or benefits; ~~and~~

3. To cooperate with the federal government, other state agencies and the State Attorney General's Office in the detection and deterrence of fraud by recipients of medical assistance or their agents*; and*

4. Assist the Virginia Health Benefit Exchange Authority in its implementation of the provisions of Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2 by:

a. Entering into one or more agreements, as described in § 38.2-6417, with the Authority, the State Corporation Commission, the Department of Health, or the Department of Social Services, which agreements shall provide for compensation of the Department of Medical Assistance Services by the Authority for expenses incurred in performing its obligations thereunder;

b. Determining eligibility of individuals for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, and the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, including the Family Access to Medical Insurance Security Plan;

c. Establishing or operating, or assisting the establishment or operation of, call centers, outreach programs, health plan enrollment, and enrollment renewals;

d. Enrolling eligible individuals in programs identified in subdivision 4 b;

e. Monitoring health care providers and health care plans; and

f. Performing such other tasks relating to the establishment and operation of the Virginia Exchange as is provided in an agreement entered into pursuant to subdivision 4 a or as is required in order to assist the Authority in complying with the applicable requirements of the Federal Act, as such term is defined in § 38.2-6401, that pertain to programs and functions of the Department of Medical Assistance Services.

§ 38.2-200. General powers of the Commission relative to insurance.

A. The Commission is charged with the execution of all laws relating to insurance and insurers. All companies, domestic, foreign, and alien, transacting or licensed to transact the business of insurance in this Commonwealth are subject to inspection, supervision and regulation by the Commission.

B. All licenses granting the authority to transact the business of insurance in this Commonwealth shall be granted and issued by the Commission under its seal. The licenses shall be in addition to the certificates of authority required of foreign corporations under §§ 13.1-757 and 13.1-919.

C. The Commission shall assist the Virginia Health Benefit Exchange Authority in its implementation of the provisions of Chapter 64 (§ 38.2-6400 et seq.) by:

1. Entering into one or more agreements, as described in § 38.2-6417, with the Authority, the Department of Medical Assistance Services, the Department of Health, and the Department of Social Services, which shall provide for compensation of the Commission by the Authority for expenses incurred in performing its obligations thereunder;

2. Determining that health carriers offering health benefit plans in the Virginia Exchange are licensed and in good standing as required by this title and the Federal Act, as such term is defined in § 38.2-6401;

3. Determining that health benefit plans offered in the Exchange, and health carriers offering such plans, as applicable, (i) provide the essential health benefits package, (ii) meet marketing requirements, (iii) utilize a streamlined application to determine eligibility for enrollment, (iv) use the standard format for presenting health plan options, (v) submit rate information, (vi) use plain language, and (vii) furnish cost-sharing information, as provided in §§ 1311(c)(1)(A), 1311(c)(1)(F), 1311(c)(1)(G), 1311(e)(2), 1311(e)(3)(B), and 1311(e)(3)(C) of the Federal Act;

4. Ensuring that health carriers charge the same premium rates for each qualified health plan without regard to whether the plan is offered inside or outside the Virginia Exchange; and

5. Performing such other tasks relating to the establishment and operation of the Virginia Exchange as is provided in an agreement entered into pursuant to subdivision 1 or as is required in order to assist the Authority in complying with the applicable requirements of the Federal Act that pertain to the regulation of the business of insurance.

§ 38.2-316. Policy forms to be filed with Commission; notice of approval or disapproval; exceptions.

A. No policy of life insurance, industrial life insurance, variable life insurance, modified guaranteed life insurance, group life insurance, accident and sickness insurance, or group accident and sickness insurance; no annuity, modified guaranteed annuity, pure endowment, variable annuity, group annuity, group modified guaranteed annuity, or group variable annuity contract; no health services plan, legal services plan, dental or optometric services plan, or health maintenance organization contract; no dental plan organization dental benefit contract; and no fraternal benefit certificate nor any certificate or evidence of coverage issued in connection with such policy, contract, or plan issued or issued for delivery in Virginia shall be delivered or issued for delivery in this Commonwealth unless a copy of the form has been filed with the Commission. In addition to the above requirement, no policy of accident and sickness insurance shall be delivered or issued for delivery in this Commonwealth unless ~~the~~*:*

1. The rate manual showing rates, rules, and classification of risks applicable thereto has been filed with the Commission*; and*

2. The policy, if offered in the individual market or small group market, is substantively identical to a policy or plan offered by the insurer that has been approved for sale in, and is being offered through, the Virginia Health Benefit Exchange established pursuant to Chapter 64 (§ 38.2-6400 et seq.), at the same premium rate both inside and outside the Exchange.

B. Except as provided in this section, no application form shall be used with the policy or contract and no rider or endorsement shall be attached to or printed or stamped upon the policy or contract unless the form of such application, rider or endorsement has been filed with the Commission. No individual certificate and no enrollment form shall be used in connection with any group life insurance policy, group accident and sickness insurance policy, group annuity contract, or group variable annuity contract unless the form for the certificate and enrollment form have been filed with the Commission.

C. 1. None of the policies, contracts, and certificates specified in subsection A of this section shall be delivered or issued for delivery in this Commonwealth and no applications, enrollment forms, riders, and endorsements shall be used in connection with the policies, contracts, and certificates unless the forms thereof have been approved in writing by the Commission as conforming to the requirements of this title and not inconsistent with law.

2. In addition to the above requirement, no premium rate change applicable to individual accident and sickness insurance policies, subscriber contracts of health services plans, dental or optometric services plans, or fraternal benefit contracts providing individual accident and sickness coverage as authorized in § 38.2-4116 shall be used unless the premium rate change has been approved in writing by the Commission. No premium rate change applicable to individual or group Medicare supplement policies shall be used unless the premium rate change has been approved in writing by the Commission.

D. The Commission may disapprove or withdraw approval of the form of any policy, contract or certificate specified in subsection A of this section, or of any application, enrollment form, rider or endorsement, if the form:

1. Does not comply with the laws of this Commonwealth;

2. Has any title, heading, backing or other indication of the contents of any or all of its provisions that is likely to mislead the policyholder, contract holder or certificate holder; or

3. Contains any provisions that encourage misrepresentation or are misleading, deceptive or contrary to the public policy of this Commonwealth.

E. Within 30 days after the filing of any form requiring approval, the Commission shall notify the

organization filing the form of its approval or disapproval of the form which has been filed, and, in the event of disapproval, its reason therefor. The Commission, at its discretion, may extend for up to an additional 30 days the period within which it shall approve or disapprove the form. Any form received but neither approved nor disapproved by the Commission shall be deemed approved at the expiration of the 30 days if the period is not extended, or at the expiration of the extended period, if any; however, no organization shall use a form deemed approved under the provisions of this section until the organization has filed with the Commission a written notice of its intent to use the form together with a copy of the form and the original transmittal letter thereof. The notice shall be filed in the offices of the Commission at least 10 days prior to the organization's use of the form.

F. If the Commission proposes to withdraw approval previously given or deemed given to the form of any policy, contract or certificate, or of any application, rider or endorsement, it shall notify the insurer in writing at least 15 days prior to the proposed effective date of withdrawal giving its reasons for withdrawal.

G. Any insurer or fraternal benefit society aggrieved by the disapproval or withdrawal of approval of any form may proceed as indicated in § 38.2-1926.

H. This section shall not apply to any special rider or endorsement on any policy, except an accident and sickness insurance policy that relates only to the manner of distribution of benefits or to the reservation of rights and benefits under such policy, and that is used at the request of the individual policyholder, contract holder or certificate holder.

I. The Commission may exempt any categories of such policies, contracts, and certificates and any applicable rate manuals from (i) the filing requirements, (ii) the approval requirements of this section, or (iii) both such requirements. The Commission may modify such requirements, subject to such limitations and conditions which the Commission finds appropriate. In promulgating an exemption, the Commission may consider the nature of the coverage, the person or persons to be insured or covered, the competence of the buyer or other parties to the contract, and other criteria the Commission considers relevant.

J. Pursuant to the authority granted by § 38.2-223, the Commission may promulgate such rules and regulations as it may deem necessary to set standards for policy and other form submissions required by this section or § 38.2-3501.

§ 38.2-1809.1. Limitations on broker compensation.

The Commission shall have the power to regulate the actions and duties of and compensation paid to agents under the terms of any agreement with an insurer issuing health benefit plans as defined in § 38.2-6401 in the Commonwealth, in order to ensure that such agreements do not provide financial incentives for the agent to direct an individual or small business either inside or outside the Virginia Health Benefit Exchange established pursuant to Chapter 64 (§ 38.2-6400 et seq.).

§ 38.2-3430.1:2. Policies to be offered on same terms as in Virginia Health Benefit Exchange.

An insurer offering a health benefit plan as defined in § 38.2-6401for sale or delivery in the individual market within the Commonwealth shall offer the same health benefit plan, for the same premium rate, inside and outside the Virginia Health Benefit Exchange established pursuant to Chapter 64 (§ 38.2-6400 et seq.).

§ 38.2-3510.1. Exchange rules applicable to policies.

Notwithstanding any provision of this chapter or Chapter 34 (§ 38.2-3400 et seq.) to the contrary, effective January 1, 2014, any provision of a health benefit plans as defined in § 38.2-6401 that is sold, issued, or issued for delivery in the individual market in the Commonwealth outside of the Virginia Health Benefit Exchange established pursuant to Chapter 64 (§ 38.2-6400 et seq.) shall be subject to the same market rules that are applicable to health benefit plans offered within the Virginia Health Benefit Exchange. The Commission shall not approve the form of any such health benefit plan that is not subject to the same market rules. As used in this section, "market rules" means the standards for the sale of individual accident and sickness insurance policies issued pursuant to § 38.2-3518.

§ 38.2-3522.1. Limits of group accident and sickness insurance.

Group accident and sickness insurance offered to a resident of this Commonwealth under a group accident and sickness insurance policy issued to a group other than one described in § 38.2-3521.1 shall be subject to the following requirements:

A. No such group accident and sickness insurance policy shall be delivered in this Commonwealth unless the Commission finds that:

1. The issuance of such group policy is not contrary to Virginia's public policy and is in the best interest of the citizens of this Commonwealth;

2. The issuance of the group policy would result in economies of acquisition or administration; ~~and~~

3. The benefits are reasonable in relation to the premiums charged*; and*

4. If the policy is offered in the small group market, the policy is offered for the same premium rate inside and outside the Virginia Health Benefit Exchange established pursuant to Chapter 64 (§ 38.2-6400 et seq.).

Insurers filing policy forms seeking approval under the provisions of this subsection shall accompany the forms with a certification, signed by the officer of the company with the responsibility for forms compliance, in which the company certifies that each such policy form will be issued only where the requirements set forth in subdivisions *A* 1 through ~~3~~ *A 4* ~~of~~ ~~this~~ ~~subsection~~ have been met.

B. No such group accident and sickness insurance coverage may be offered in this Commonwealth by an insurer under a policy issued in another state unless this Commonwealth or another state having requirements substantially similar to those contained in subdivisions *A* 1, *A* 2, ~~and~~ *A* 3, *and A 4* ~~of~~ ~~subsection~~ ~~A~~ has made a determination that such requirements have been met.

1. An insurer offering group accident and sickness insurance coverage in this Commonwealth under this subsection shall file a certification, signed by the officer of the company having responsibility for forms compliance, in which the company certifies that all group insurance coverage marketed to residents of this Commonwealth under policies which have not been approved by this Commonwealth will comply with the provisions of § 38.2-3521.1 or have met the requirements set forth in subdivisions A 1 through A ~~3~~ ~~of~~ ~~this~~ ~~section~~ *4*, and which clearly demonstrates that the substantially similar requirements of the state in which the contract will be issued have been met. The certification shall be accompanied by documentation from such state, evidencing the determination that such requirements have been met.

2. An insurer offering group accident and sickness insurance in this Commonwealth under this subsection that is unable to provide the documentation required in subdivision 1 of this subsection shall be required to file policy forms consistent with requirements in § 38.2-316 which are imposed on policies issued in Virginia. The policy shall be required to be approved as meeting all requirements of this title prior to its being offered to residents of this Commonwealth.

C. The premium for the policy shall be paid either from the policyholder's funds or from funds contributed by the covered persons, or from both.

D. An insurer may exclude or limit the coverage on any person as to whom evidence of individual insurability is not satisfactory to the insurer, except as otherwise prohibited in this title.

E. Effective January 1, 2014, any provision of an accident and sickness insurance policy that is sold, issued, or issued for delivery in the Commonwealth in the small group market outside of the Virginia Health Benefit Exchange established pursuant to Chapter 64 (§ 38.2-6400 et seq.) shall be subject to the same market rules that are applicable to policies offered within the Virginia Health Benefit Exchange. The Commission shall not approve the form of any such policy that is not subject to the same market rules. As used in this section, "market rules" means the standards for the sale of individual accident and sickness insurance policies issued pursuant to § 38.2-3518.

§ 38.2-3523.4. Minimum number of persons covered.

A group accident and sickness insurance policy shall on the issue date and at each policy anniversary date, cover at least two persons, other than spouses or minor children, unless such spouse or minor child is determined to be an eligible employee as defined in § 38.2-3431. *However, if the federal Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, and regulations issued thereunder, requires that health benefit plans be offered in the SHOP exchange, as defined in § 38.2-6401, to qualified employers with one employee, then a group accident and sickness policy shall cover at least one person who is a bona fide employee of the qualified employer or the qualified employer itself if a sole proprietorship.*

CHAPTER 64.

VIRGINIA HEALTH BENEFIT EXCHANGE ACT.

§ 38.2-6400. Short title.

This chapter shall be known and may be cited as the "Virginia Health Benefit Exchange Act."

§ 38.2-6401. Definitions.

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

"Actuarial value" means the level of coverage provided by a qualified health plan denoted as platinum, gold, silver, or bronze, as defined in § 1302(d) of the Federal Act.

"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 by qualified individuals.

"Applicant" means (i) an individual who is seeking eligibility through an application to the Exchange for at least one of the following: (a) enrollment in a qualified health plan through the American Health Benefit Exchange; (b) advance payments of the premium tax credit and cost-sharing reductions; or (c) Medicaid or CHIP, or (ii) an employer or employee seeking eligibility for enrollment in a qualified health plan through the SHOP exchange.

"Authority" means the Virginia Health Benefit Exchange Authority created as a political subdivision of the Commonwealth pursuant to this chapter.

"Board" means the boards of directors for the Authority created pursuant to this chapter.

"Bureau" means the Bureau of Insurance within the Commission.

"Catastrophic plan" means a health benefit plan that meets the requirements for a catastrophic plan under 42 U.S.C. § 18022(e) and that is offered through the Exchange.

"Cost sharing" means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for noncovered services.

"Cost-sharing reductions" means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian who is enrolled in a qualified health plan in the Exchange.

"Department" means the Department of Medical Assistance Services.

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

"Enrollee" means a qualified individual or qualified employee enrolled in a qualified health plan.

"ERISA" means the Employee Retirement Income Security Act of 1974 (29 U.S.C. § 1001 et seq.).

"Essential health benefits package" means, with respect to any health benefit plan, coverage that (i) provides the essential health benefits determined by the Board pursuant to subsection L of § 38.2-6404, (ii) limits cost sharing for such coverage in accordance with § 1302(c) of the Federal Act, and (iii) subject to § 1302(e) of the Federal Act, provides either the bronze, silver, gold, or platinum level of coverage designated in § 1302(d) of the Federal Act.

"Exchange" means, as the context requires, either (i) the Virginia Health Benefit Exchange Authority 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 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.

"Executive Director" means the chief administrative officer of the Exchange.

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

"Group health plan" means an employee welfare benefit plan as defined in § 3(1) of ERISA to the extent that the plan provides medical care within the meaning of § 733(a) of ERISA to employees, including both current and former employees, or their dependents as defined under the terms of the plan directly or through insurance, reimbursement, or otherwise.

"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 an employer.

"Health benefit 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, or 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 § 882(g)(1) of the Social Security Act; coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services); or similar supplemental coverage provided to coverage under a group health plan.

"Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of the

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

"Individual market" means the market for health insurance coverage offered to individuals other than in connection with a group health plan.

"Large employer" means in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

"Navigator" means a public or private entity or an individual that is qualified to provide information on or enroll qualified individuals in a qualified health plan or a state medical assistance program.

"Qualified dental plan" means a limited scope dental plan that has been certified in accordance with subsection E of § 38.2-6411.

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

"Qualified employer" means a small employer that elects to make all of its full-time employees eligible for one or more qualified health plans in the small group market offered through the SHOP exchange, and at the employer's option, to 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. Beginning in 2017, if the Exchange allows large employers to purchase coverage through the SHOP exchange, the term shall include a large employer that elects to make all full-time employees of such employer eligible for one or more qualified health plans in the large group market offered through the SHOP exchange.

"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 § 38.2-6411.

"Qualified individual" means an individual, including a minor, who (i) is seeking to enroll in a qualified health 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 federal 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 employees and their dependents with access to one or more qualified health plans.

"Small employer" means an employer that employed an average of at least two but not more than (i) prior to January 1, 2016, 50 employees during the preceding calendar year or (ii) commencing January 1, 2016, 100 employees during the preceding calendar year. For the purposes of this definition: (a) all persons treated as a single employer under subsection (b), (c), (m), or (o) of 26 U.S.C. § 414 shall be treated as a single employer; (b) an employer and any predecessor employer shall be treated as a single employer; and (c) all employees shall be counted, including part-time employees and employees who are not eligible for health insurance coverage through the employer. If an employer was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer shall be based on the average number of employees reasonably expected to be employed by the employer on business days in the current calendar year. An employer that makes enrollment in qualified health plans available to its 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 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 or a contract for a health-related condition that (i) includes coverage for specific health care services or benefits; (ii) places limitations or restrictions on deductibles, coinsurance, copayments, or any annual or lifetime maximum benefit amounts; or (iii) includes a specific category of licensed health care practitioners from whom an insured is entitled to receive care. "State-mandated health benefit" includes, without limitation, any coverage, or the offering of coverage, of a benefit or provider pursuant to §§ 38.2-3407.5 through 38.2-3407.6:1, 38.2-3407.9:01, 38.2-3407.9:02, 38.2-3407.11 through 38.2-3407.11:3, 38.2-3407.16,

38.2-3408, 38.2-3411 through 38.2-3414.1, 38.2-3418 through 38.2-3418.17, and 38.2-4221. For purposes of this chapter, "state-mandated health benefit" does not include a benefit that is mandated by federal law.

§ 38.2-6402. Declaration of public purpose.

A. The General Assembly finds and declares that:

1. The Federal Act allows each state to establish a health benefit exchange through state law or opt to participate in a national health benefit exchange operated by the federal Department of Health and Human Services;

2. The Federal Act requires each state to establish a health benefit exchange to perform certain duties and take certain responsibilities set forth in the Federal Act or make sufficient progress in the creation of a health benefit exchange by January 1, 2013, or default to a federally run health benefit exchange;

3. While uncertainty exists regarding the constitutionality of the Federal Act, and concerns exist regarding the regulatory and fiscal burdens imposed on the Commonwealth by the Federal Act, the establishment of a health benefit exchange managed by the Commonwealth is deemed prudent and advisable; and

4. The establishment of the American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in the Commonwealth and the establishment of the SHOP exchange to assist qualified small employers in the Commonwealth in facilitating the enrollment of their employees and their dependents in qualified health plans will reduce the number of individuals without health insurance in the Commonwealth, provide a transparent marketplace and consumer education, and assist individuals with access to assistance programs, premium assistance, tax credits, and cost-sharing reductions.

B. The General Assembly further declares that the creation of the Authority and the establishment and operation of the Virginia Health Benefit Exchange are in the public interest, serves a public purpose, and will promote the health, safety, welfare, convenience, or prosperity of the people of the Commonwealth.

§ 38.2-6403. Authority created.

A. To effectuate the purposes provided for in this chapter, the Virginia Health Benefit Authority is hereby created as a public body corporate and as a political subdivision of the Commonwealth. The Authority's exercise of the powers and duties conferred by this chapter shall be deemed the performance of an essential governmental function and matters of public necessity for which public moneys may be spent and private property acquired. The Authority is designated as the agency to establish, govern, and operate the Exchange on behalf of the Commonwealth.

B. The Authority may do business as the "Virginia Exchange," and any references in this Code or in any regulations adopted thereunder that refer to the Virginia Exchange shall, whenever necessary, be deemed to refer to the Authority.

§ 38.2-6404. Board of directors; appointment and tenure of members; quorum; compensation.

A. The Authority shall be governed by a 12-member board of directors consisting of seven nonlegislative citizen members and five ex officio nonvoting members. The citizen members shall be appointed by the Governor, subject to confirmation by the General Assembly. The citizen members shall have the following qualifications: (i) two appointees shall represent the interests of small businesses, including one small business owner; (ii) two appointees shall represent the interests of consumers and shall have demonstrated expertise in public health insurance programs and the needs of low-income, disabled, and uninsured populations; (iii) one appointee shall have expertise in insurance actuarial science; and (iv) two appointees shall have expertise in at least one of the following areas: consumer protection, individual health care coverage, small employer health care coverage, health benefit plan administration, and health care financing. The Secretary of Health and Human Resources, the Commissioner of Insurance, the Commissioner of Health, the Commissioner of the Department of Social Services, and the Director of the Department shall serve as ex officio nonvoting members.

B. No member of the Board shall be an individual who is an employee of a health insurance issuer, as defined in § 2725 of the Public Health Service Act (42 U.S.C. § 300 gg), or employed as a health insurance agent or broker. In making appointments to the Board, the Governor shall not appoint more than one individual from any one commercial or industrial field. A majority of the citizen members shall have relevant knowledge or experience in at least one of the following:

1. Health benefits administration;

2. Health care finance;

3. Health plan purchasing;

4. Health care delivery system administration;

5. Public health; or

6. Health policy issues related to the individual health insurance market or small employer health

insurance market and the uninsured.

C. The terms of members serving by virtue of their office shall expire upon termination of their holding such office. Citizen members of the Board shall be appointed for terms of two years each, except appointments to fill vacancies, which shall be for the remainder of the unexpired terms. No member shall serve for more than two consecutive two-year terms, except that any member appointed to the unexpired term of another shall be eligible to serve two consecutive full two-year terms. Vacancies shall be filled in the manner of the original appointments. Members shall continue to serve until such time as their successors have been appointed and duly qualified to serve. Immediately after their appointments, members shall enter upon the performance of their duties.

D. Each member shall be compensated from funds of the Authority at the rate per day specified in § 2.2-2813 for each day or portion thereof in which the member is engaged in the business of the Authority. In addition, members shall be reimbursed for all reasonable and necessary expenses incurred in the performance of their duties as provided in §§ 2.2-2813 and 2.2-2825.

E. The Board shall meet at least quarterly and may hold such special meetings as it deems appropriate. The meetings of the Board shall be held at the call of the chairman or whenever two members so request.

F. Five members of the Board, two of whom are citizen members, shall constitute a quorum. Any action taken by the Board under the provisions of this chapter may be authorized by resolution approved by a majority of the members who are present at any regular or special meeting. No vacancy in the membership of the Board shall impair the right of a quorum to exercise all the rights and perform all the duties of the Board.

G. The Authority may use its funds, and may obtain liability insurance or provide self-insurance, for the payment or reimbursement of costs and expenses, including amounts paid or to be paid in satisfaction of judgment or settlement, penalties, attorney fees and expenses, and court costs, that are incident to any liability of its members and employees arising from the performance or discharge of their official duties and such other activities as the members of the Board may by resolution approve for the purpose of making such payment or reimbursement or providing such insurance or self-insurance.

H. A Board member may be removed for malfeasance, misfeasance, incompetence, or gross neglect of duty by the individual that appointed him or, if such appointing individual no longer holds the office creating the right of appointment, by the current holder of that office.

I. The Board shall appoint an advisory committee of up to 12 individuals for the purpose of gathering information and expertise relevant to the operations of the Exchange and issues pending before the Board. The advisory committee shall be composed of at least two representatives from each of the following: advocates for low-income consumers, small businesses, health care providers, insurance agents, and health carriers. Members of an advisory board shall not be entitled to compensation or reimbursement of expenses.

J. All appointments of citizen members, including the initial appointments to the Board and appointments to fill vacancies, are subject to confirmation by the affirmative vote of a majority of those voting in each house of the General Assembly if in session when such appointments are made and, if not in session, at its first regular session subsequent to such appointment. Any member whose nomination is subject to confirmation during a regular session of the General Assembly shall be deemed terminated when the General Assembly rejects the nomination or when it adjourns without confirming the nomination, whichever is earlier. No such termination shall affect the validity of any action taken by such member prior to such termination.

K. The Board may employ technical experts and such other agents and employees, permanent or temporary, as it may require, and shall determine their qualifications, duties, and compensation. The Board may delegate to one or more of its agents or employees such administrative duties as it may deem proper.

L. The Board shall determine the essential health benefits. In doing so, the Board shall select as the benchmark plan, which will serve as a reference plan reflecting the scope of services and limits offered by a typical employer plan, either (i) the largest state employee health plan by enrollment or (ii) the largest insured commercial non-Medicaid health maintenance organization operating in the Commonwealth. Notwithstanding the foregoing, the essential health benefits shall (a) encompass the 10 categories of services identified in § 1302(b)(1) of the Federal Act and (b) include all state-mandated health benefits.

§ 38.2-6405. Officers of the Board.

A. The members annually shall elect (i) from among their number a chairman and vice-chairman and (ii) such other subordinate officers as the Board may determine, who need not be members of the Board. The Executive Director shall serve as secretary of the Board.

B. Notwithstanding the provisions of any other law, no officer or employee of the Commonwealth shall be deemed to have forfeited or shall forfeit his office or employment by reason of his acceptance of membership on the Board.

§ 38.2-6406. Conflicts of interests.

Members of the Board and employees of the Authority, including the Executive Director, shall be subject to the standards of conduct set forth in the State and Local Government Conflict of Interests Act (§ 2.2-3100 et seq.) and may be removed from office for inefficiency, neglect of duty, or misconduct in the manner set forth therein.

§ 38.2-6407. Appointment and functions of Executive Director.

A. The Authority shall be under the immediate supervision, management, and direction of an Executive Director, subject to the policies, control, and direction established by the Board. The Executive Director shall be appointed by the Board, provided that the Executive Director shall not be a member of the Board. The conditions of appointment, including salary, shall be made by the Board. The Board annually shall evaluate the performance of the Executive Director. The Executive Director shall serve at the pleasure of the Board.

B. The Executive Director shall devote his full time to the performance of his official duties and shall not be engaged in any other profession or occupation.

C. The Executive Director shall supervise and administer the operation of the Exchange in accordance with the provisions of this chapter. In addition, the Executive Director shall serve as the secretary of the Board. As secretary of the Board, the Executive Director shall (i) attend all meetings and keep minutes of all proceedings of the Board, (ii) be custodian of all books, documents, and papers filed with the Authority and of its minute book and seal, and (iii) have authority to cause to be made copies of all minutes and other records and documents of the Authority and to give certificates under the seal of the Authority to the effect that such copies are true copies and all persons dealing with the Authority may rely upon such certificates.

D. In addition to any other duties set forth in this chapter, the Executive Director shall:

1. Direct, manage, and supervise the operations and activities of the Exchange in accordance with the Authority's rules, regulations, and policies;

2. Employ or retain such qualified employees subordinate to the Executive Director as shall be necessary for carrying out the purposes of this chapter and fulfilling the duties of the Authority that are conferred upon the Executive Director, and to determine their qualifications, duties, and compensation, in accordance with the personnel policies adopted by the Board pursuant to subsection B of § 38.2-6420.

3. Approve all accounts for salaries, per diem payments, and allowable expenses of the Authority and its employees and approve all expenses incidental to the operation of the Exchange;

4. Advise and assist the Board in developing a budget;

5. Report to the Board on all operations of the Exchange;

6. Actively recruit plans to participate in and to compete within the Exchange, pursuant to parameters established by the Board; and

7. Perform any other duty that the Authority requires for carrying out the provisions of this chapter.

§ 38.2-6408. Powers of the Exchange generally.

The Exchange shall have and may exercise all powers necessary or appropriate to carry out its corporate purposes and the provisions of this chapter, including, without limitation, the power to:

1. Have perpetual succession as a public body corporate and as a political subdivision of the Commonwealth;

2. Sue and be sued, implead and be impleaded, and complain and defend in all courts in its own name;

3. Have an official seal and alter it at will, although the failure to affix this seal shall not affect the validity of any instrument executed on behalf of the Authority;

4. Maintain an office at any place within the Commonwealth as it may designate, and to lease or rent any dwellings, houses, accommodations, lands, buildings, structures, or facilities to effectuate the purposes of this chapter;

5. Adopt and from time to time amend and repeal rules and bylaws, not inconsistent with this chapter, governing the manner in which the powers of the Authority shall be exercised and its duties performed;

6. Make, enter into, and execute contracts, memoranda of understanding, and all other instruments and agreements necessary, incidental, or convenient for the performance of its duties and the exercise of its powers and functions under this chapter, including contracts with any department, agency, or instrumentality of the United States, the Commonwealth or locality, any state, an existing public or private health benefit exchange or clearinghouse, or an eligible entity to perform functions or provide services in connection with the operation of the Exchange and for any other purpose consistent with this chapter;

7. Receive and accept from any source aid, grants, and contributions of money, property, labor, or other things of value to be held, used, and applied to carry out the purposes of this chapter subject to

the conditions upon which the aid, grants, or contributions are made;

8. Conduct or engage in any lawful business, activity, effort, or project consistent with the Authority's purposes or necessary or convenient to exercise its powers, and to establish, revise, charge, and collect fees and charges in connection with any agreements made by the Exchange under this chapter;

9. Acquire or lease personal property, or any interest therein; and to sell, lease, encumber, mortgage, or otherwise dispose of any property so acquired or leased;

10. Procure such insurance, participate in such insurance plans, or provide such self-insurance as it deems necessary or convenient to carry out the purposes and provisions of this chapter. The purchase of insurance, participation in an insurance plan, or creation of a self-insurance plan by the Authority shall not be deemed a waiver or relinquishment of any sovereign immunity to which the Authority or its officers, directors, employees, or agents are otherwise entitled;

11. Invest its funds as provided in this chapter or permitted by applicable law;

12. Develop policies and procedures regarding payment to contractors that are consistent with Article 4 (§ 2.2-4347 et seq.) of Chapter 43 of Title 2.2;

13. Borrow money for the purpose of obtaining working capital;

14. Employ its own counsel and legal staff or make use of legal services made available to it by the Commission or other public body, or both; and

15. Do any act necessary or convenient to the exercise of the powers granted to it by law or reasonably implied and perform any act or carry out any function not inconsistent with state law that may be useful in carrying out the provisions of this chapter.

§ 38.2-6409. Duties of the Exchange.

The Exchange shall:

1. Implement procedures for the certification, recertification, and decertification, consistent with this chapter and guidelines developed by the Secretary under § 1311(c) of the Federal Act, of health benefit plans as qualified health plans;

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

3. Provide for the operation of a toll-free telephone call center that addresses the needs of consumers requesting assistance;

4. Maintain an up-to-date publicly accessible website that:

a. Provides standardized comparative information on each available qualified health plan, including at a minimum (i) premium and cost-sharing information; (ii) the summary of benefits and coverage established under the Federal Act; (iii) identification of whether the qualified health plan is a bronze, silver, gold, or platinum level plan as defined by § 1302(d) of the Federal Act or a catastrophic plan as defined by § 1302(e) of the Federal Act; (iv) the results of an enrollee satisfaction survey, 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 under § 38.2-6411; and (viii) the provider directory made available to the Exchange;

b. Is accessible to people with disabilities and provides meaningful access for persons with limited English proficiency;

c. Publishes the following financial information: (i) the average costs of licensing required by the Exchange; (ii) any regulatory fees required by the Exchange; (iii) any payments required by the Exchange in addition to fees under clauses (i) and (ii); (iv) administrative costs of such Exchange; and (v) moneys lost to waste, fraud, and abuse;

d. Provides applicants with information about Navigators and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in subdivision 3;

e. Allows for eligibility determinations to be made;

f. Allows for enrollment in coverage; and

g. Allows for renewal of coverage;

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 42 U.S.C. § 300gg-15;

8. Inform individuals, in accordance with § 1413 of the Federal Act, of eligibility requirements for the Medicaid program under Title XIX of the Social Security Act, as amended from time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, including the Family Access to Medical Insurance Security Plan, as amended from time to time, or 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. Establish and make available by electronic means 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 a SHOP exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Program at the specified level of coverage;

11. Issue certificates of exemption consistent with §§ 1311(d)(4)(H) and 1411 of the Federal Act;

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 Authority under 42 U.S.C. § 18081 that the individual has changed employers and (ii) each individual who ceases coverage under a qualified health plan during the plan year and the effective date of that cessation;

13. Provide to each employer the name of each of the employer's employees described in subdivision 12 c 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. Have a consumer education function, including a Navigator program, and refer consumers to consumer assistance programs in the Commonwealth when available and appropriate under guidelines established for agents and Navigators;

16. Select entities qualified to serve as Navigators in accordance with § 1311(i) of the Federal Act and standards developed by the Secretary and award grants to Navigators as provided in § 38.2-6427;

17. Monitor the stability of the individual and small group markets and the availability of plans and the sufficiency of the provider networks throughout the Commonwealth, and review the rate of premium growth within the Exchange and outside the Exchange;

18. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled in accordance with § 10108 of the Federal Act and collect the amount credited from the offering employer;

19. Keep an accurate accounting of all activities, receipts, and expenditures and annually submit to the Secretary, the Governor, the Commission, and the General Assembly a report concerning such accountings as provided in subdivision B 5 of § 38.2-6425;

20. Meet the following financial integrity requirements:

a. 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

b. 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;

21. Have the discretion to temporarily adjust market rules inside or outside the Exchange if, in the combined judgment of the Board and the Governor, extreme adverse selection threatens the financial integrity and competitive potential of the Exchange or of the individual market, small group market, or both, outside of the Exchange. Temporary adjustments to market rules may include (i) freezes in enrollment in certain plans or (ii) adjustments to any risk adjustment algorithm. Any such adjustment shall not extend further than the July 1 following the next regular session of the General Assembly, during which session reports on the need for the adjustments shall be submitted by the Bureau, the Executive Director, and relevant stakeholders to suspend temporarily enrollments in qualified health plans through the Exchange or to make temporary adjustments to a risk adjustment algorithm as the Board determines is necessary to stabilize the market;

22. Provide that qualified employers may access coverage through the SHOP exchange for their employees that shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP exchange at the specified level of coverage;

23. Consult with stakeholders relevant to carrying out the activities required under this chapter, as provided in § 1311(d)(6) of the Federal Act;

24. Collaborate with appropriate agencies of the Commonwealth, to the extent possible, to allow an enrollee who loses premium tax credit eligibility under 26 U.S.C. § 36B and is eligible for any state or local public program to remain enrolled in a qualified health plan or enroll in such public program without any gap in coverage;

25. Assist in the implementation of reinsurance and risk adjustment mechanisms for qualified health plans as required by the Federal Act;

26. Provide for the processing of applications for coverage under a qualified health plan, the enrollment of persons in qualified health plans, and the disenrollment of persons in qualified health plans and establish one streamlined and seamless application, enrollment, and reenrollment process for both the Exchange and the Commonwealth's Medicaid program and FAMIS programs;

27. Establish billing and payment policies for issuers of qualified health plans, which policies shall offer enrollees and small employers the option of having the Exchange collect and administer premiums, including through allocation of premiums among the various health carriers issuing qualified health plans chosen by individual employers;

28. Permit agents and brokers to (i) enroll qualified individuals, qualified employers, or qualified employees in any qualified health plans in the individual or small group market as soon as the qualified health plan is offered through the Exchange and (ii) assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for qualified health plans. The Exchange may elect to provide information regarding licensed agents and brokers on its website for the convenience of consumers seeking insurance through that Exchange;

29. Conduct outreach and education activities to educate consumers about the Exchange, encourage participation by consumers and health carriers in the Exchange, and publicize (i) the existence of the Exchange, (ii) the Exchange's eligibility requirements and enrollment procedures, and (iii) the benefits and advantages of purchasing coverage through the Exchange; and

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

§ 38.2-6410. Requirements of the Exchange.

A. The Authority shall establish and administer the Virginia Health Benefit Exchange in accordance with the requirements of the Federal Act, regulations promulgated under the Federal Act, and this chapter. The Exchange shall consist of an American Health Benefit Exchange for the individual market and the SHOP exchange for the small group market, which shall be operated jointly as authorized pursuant to § 1311(b)(2) of the Federal Act.

B. The Exchange shall facilitate the purchase and sale of qualified health plans and allow qualified health plans to participate in the Exchange.

C. Qualified health plans shall be made available to qualified individuals and qualified employers through the Exchange beginning with effective dates on or before January 1, 2014.

D. The Exchange shall not make available any health benefit plan that is not a qualified health plan. However, a health carrier may be allowed to offer a plan that provides limited scope dental benefits meeting the requirements of 26 U.S.C. § 9832(c)(2)(A) through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of § 1302(b)(1)(J) of the Federal Act.

E. Neither the Exchange nor a health carrier offering health benefit plans through the Exchange shall charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because (i) the individual has become newly eligible for that coverage or (ii) the individual's employer-sponsored coverage has become affordable under the standards of 26 U.S.C. § 36B(c)(2)(C).

F. Appeals of decisions by the Exchange or the Bureau denying a request for certification or decertifying a health benefit plan as a qualified health plan shall be heard by the Commission in accordance with its rules of practice and procedure.

G. The Exchange shall not adopt rules or regulations that conflict with or prevent the application of regulations promulgated by the Secretary under Subtitle D of Title I of the Federal Act.

H. In order to ensure that the markets for health benefit plans in the Commonwealth do not develop in a manner whereby (i) only qualified health plans providing a bronze level of coverage are offered outside of the Exchange and (ii) only qualified health plans providing a silver or gold level of coverage are offered through the Exchange, a health carrier offering a health benefit plan through the Exchange shall not offer a health benefit plan providing a bronze level of coverage outside of the Exchange unless

it offers a qualified health plan providing a bronze level of coverage through the Exchange.

§ 38.2-6411. Certification of health benefit plans as qualified health plans.

A. The Authority may certify a health benefit plan as a qualified health plan if:

1. The plan provides the essential health benefits package and complies with any other requirements of any other provision of this title, except that the plan shall not be required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection E, if (i) the Authority has determined that at least one qualified dental plan is available to supplement the plan's coverage and (ii) the health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Authority, that such plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by such plan are offered through the Exchange;

2. The rates and forms have been approved by the Bureau;

3. The plan provides at least a bronze level of coverage, as determined pursuant to subdivision 6 of § 38.2-6409, unless the plan is certified as a qualified catastrophic plan, meets the requirements of the Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

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

5. The health carrier offering the plan:

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

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

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 or broker;

d. Does not charge any cancellation fees or penalties; and

e. Complies with the regulations developed by the Secretary under § 1311(d) of the Federal Act and such other requirements as the Authority is authorized to establish pursuant to this chapter; and

f. Offers the same health plans for the same premium rates inside and outside of the Exchange as required by § 38.2-3518;

6. The plan meets the requirements of certification as adopted by regulation adopted pursuant to § 38.2-6423 or promulgated by the Secretary under § 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance;

7. The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in the Commonwealth; and

8. The plan provides the same mandated health benefits that are required to be provided in any health benefit plan offered outside of the Exchange.

B. The Authority 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 rate controls by the Exchange, (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, or (iv) for any other reason that is not required by any specific provision of this chapter or by the Federal Act.

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

1. Agree to submit a justification for any premium increase before implementation of such increase. The health carrier shall prominently post such justification and any information related to such justification on its website. The Exchange shall take such justification and information into consideration, along with (i) any additional information and recommendations provided to the Exchange by the Bureau under § 2794(b) of the Public Health Service Act, 42 U.S.C. § 300gg-94, and (ii) any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by other states to the Secretary, when determining whether to allow the health carrier to continue to make such plan available through the Exchange;

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

a. Claims payment policies and practices;

b. Periodic financial disclosures;
c. Data on enrollment;
d. Data on disenrollment;
e. Data on the number of claims that are denied;
f. Data on rating practices;
g. Information on cost sharing and payments with respect to any out-of-network coverage;
h. Information on enrollee and participant rights under Title I of the Federal Act; and
i. Other information as determined appropriate by the Secretary or the Authority; and

3. Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that such individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider, which information shall be made available as provided in subdivisions 3 and 4 of § 38.2-6409.

D. The Authority shall not exempt any health carrier seeking certification of a health benefit plan as a qualified health plan from state licensure or reserve requirements and 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.

E. 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 Authority 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 essential 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. Health carriers may jointly offer a comprehensive plan through the Exchange in which dental benefits are provided by a health carrier through a qualified dental plan and health benefits are provided by another health carrier through a qualified health plan, provided the plans are priced separately and are also made available for purchase separately at the same price.

F. The Exchange shall collect and analyze plan rate and benefit package information; monitor and oversee carriers; conduct ongoing carrier account management; perform carrier outreach and training; and collect and analyze data regarding quality.

§ 38.2-6412. Funding.

A. The Exchange is authorized to fund its operations through revenues generated by assessments or user fees on all carriers, without regard to whether the carriers offer plans through the Exchange, and such funds, if any, that the General Assembly may appropriate for such purpose. The Authority shall have authority to establish the amount of such assessments or fees, and the manner of their remittance and collection, by regulation. Any assessments or fees assessed by the Authority shall be set at a level that generates funding that, when added to any funds appropriated by the General Assembly, is sufficient to support the operations of the Exchange commencing January 1, 2015.

B. The Authority shall publish the average costs of assessments or fees assessed by the Exchange and the administrative costs of the Exchange, including information on moneys lost to waste, fraud, and abuse, on a website to educate individuals on such costs.

C. The Exchange may create and establish one or more special funds, herein referred to as "reserve funds," and shall pay into each such reserve fund (i) any moneys appropriated and made available by the Commonwealth for the purpose of such fund and (ii) any other moneys that may be made available to the Exchange for the purpose of such fund from any other source or sources. All moneys held in any reserve fund shall be used, as required, solely for the operation of the Exchange.

§ 38.2-6413. Grants or loans of public or private funds.

A. The Authority shall pursue available federal funding for operation of the Exchange, including planning and establishment grants made available to the Exchange pursuant to § 1311 of the Federal Act. If an Executive Director has not been appointed under § 38.2-6407 when the Secretary makes the planning and establishment grants available, the chairman of the Board shall submit the initial application for planning and establishment grants to the Secretary. The Board shall be responsible for using the funds awarded by the Secretary for the planning and establishment of the Exchange, consistent with § 1311(b) of the Federal Act.

B. The Authority may apply for and accept, receive, receipt for, disburse, and expend federal and state moneys and other moneys, public or private, made available by grant or loan or as gifts, donations, and bequests, to accomplish any of the purposes of this chapter.

C. All federal moneys accepted under this section shall be accepted and expended by the Authority upon such terms and conditions as are prescribed by the United States and as are consistent with state law; and all state moneys accepted under this section shall be accepted and expended by the Authority upon such terms and conditions as are prescribed by the Commonwealth. The Board shall have the power to comply with such terms and conditions and execute such agreements as may be necessary, convenient, or desirable, consistent with policies, rules, and regulations of the Board.

D. The Commonwealth may make grants of money or property to the Exchange for the purpose of enabling it to carry out its corporate purposes and for the exercise of its powers, including, but not limited to, deposits to the reserve funds. This section shall not be construed to limit any other power the Commonwealth may have to make such grants to the Exchange.

§ 38.2-6414. Moneys of authority; investments.

A. All moneys of the Exchange except as otherwise authorized or provided in this chapter shall be deposited as soon as practicable in a separate account or accounts in banks or trust companies organized under the laws of the Commonwealth, in national banking associations, in federal home loan banks, or to the extent then permitted by law in savings institutions organized under the laws of the Commonwealth or the United States. The moneys in such accounts shall be paid out on checks, drafts payable on demand, electronic wire transfers, or other means authorized by the Exchange. Each payment shall be approved by the Executive Director or such other officers or employees of the Exchange as the board shall authorize. Deposits of such moneys shall, if required by the Exchange, be secured as it shall prescribe, and all banks and trust companies are authorized to give such security for such deposits.

B. Unless otherwise limited by contract with any party making loans to the Exchange, any moneys of the Exchange and any moneys held in trust or otherwise for the payment of such loans may be invested in (i) obligations or securities that are considered lawful investments for fiduciaries, both individual and corporation, as set forth in § 26-40, and (ii) any investments and deposits authorized by Chapter 45 (§ 2.2-4500 et seq.) of Title 2.2.

C. Whenever investments are made in accordance with this section, no member of the board or employee of the Exchange shall be liable for any loss therefrom in the absence of negligence, malfeasance, misfeasance, or nonfeasance on his part.

§ 38.2-6415. Applicability of Freedom of Information Act.

A. The Authority shall be subject to the provisions of the Freedom of Information Act (§ 2.2-3700 et seq.), which shall include the exclusions set forth in subdivision 30 of § 2.2-3705.7 and subdivision A 46 of § 2.2-3711.

B. For purposes of the Freedom of Information Act, meetings of the Board may be conducted through telephonic or video means as provided in subsection B of § 2.2-3708 or similar provisions of any successor law.

§ 38.2-6416. Information-sharing agreements.

The Authority may enter into information-sharing agreements with federal and state agencies to carry out the Authority's responsibilities under this chapter. An agreement entered into under this section must include adequate protection with respect to the confidentiality of any information shared and comply with all applicable state and federal law.

§ 38.2-6417. Interagency agreements; duties of other agencies.

A. The Authority, the Department, the Department of Health, the Department of Social Services, and the Commission are authorized to enter into one or more agreements with each other, which may be in the form of memoranda of understanding:

1. Providing for the division among the Authority, the Department, the Department of Health, the Department of Social Services, and the Commission of functions and tasks associated with the establishment and operation of the Exchange, certification of health plans, facilitating and coordinating enrollment, case management, and renewals of Medicaid and the Family Access to Medical Insurance Security Plan eligibility;

2. Providing that the Commission, through the Bureau, shall make determinations regarding:

a. Whether health carriers satisfy the requirements established by this chapter and other chapters of this title, including, but not limited to, requirements regarding licensure and solvency; and

b. Whether a health benefit plan proposed to be offered through the Exchange satisfies the requirements of §§ 1301(a)(1); 1311(c)(1)(A), (F), and (G); and 1311(e)(2) of the Federal Act and regulations promulgated thereunder;

3. Providing that the Commission, through the Bureau's market conduct examinations and investigation of consumer complaints, shall determine whether health carriers are complying with the requirements of § 1311(e)(3)(B) of the Federal Act and regulations promulgated thereunder;

4. Providing that the Department shall make determinations regarding the eligibility of individuals for benefits under the Medicaid program under Title XIX of the Social Security Act, as amended from

time to time, the Children's Health Insurance Program (CHIP) under Title XXI of the Social Security Act, including the Family Access to Medical Insurance Security Plan, as amended from time to time, or any applicable state or local public health benefits program; or

5. Providing that the Department of Health shall determine whether health carriers are complying with the requirements of §§ 1311(c)(1)(B) and 1311(c)(1)(C), (E), and (H) of the Federal Act and regulations promulgated thereunder.

B. Any agreement entered into pursuant to this section shall provide for the reimbursement by the Authority of the additional expenses incurred by the Commission or Department in performing its obligations under the agreement. Such reimbursement shall include the Commission's expenses incurred in collecting and remitting any fees assessed pursuant to § 38.2-6412.

C. The Commission shall determine that a plan seeking certification or recertification as a qualified health plan meets all requirements related to licensure and solvency and any other of the requirements of the Federal Act that relate to requirements that are under Commission oversight.

§ 38.2-6418. Forms of accounts and records; audit; annual report.

A. The accounts and records of the Authority showing the receipt and disbursement of funds from whatever source derived shall be in a form prescribed by the Auditor of Public Accounts.

B. The accounts of the Authority shall be audited annually by certified public accounting firm selected by the Authority through a process of competitive negotiation. The audit shall be reviewed by the Auditor of Public Accounts. The cost of such audit and review shall be borne by Authority.

C. Copies of the annual audit shall be submitted as required by subsection A of § 38.2-6425.

D. The Auditor of Public Accounts and his legally authorized representatives are hereby authorized and empowered from time to time to examine the accounts and books of the Authority; however, the Authority shall not be deemed to be a state or governmental agency, advisory agency, or public body or agency or instrumentality for purposes of Chapter 14 (§ 30-130 et seq.) of Title 30.

E. The Authority shall be subject to periodic external review under the provisions of the Legislative Program Review and Evaluation Act (§ 30-65 et seq.).

§ 38.2-6419. Exemptions from taxes or assessments.

As set forth in § 38.2-6402, the Authority will be performing essential governmental functions in the exercise of the powers conferred upon it by this chapter. Accordingly, the Authority shall not be required to pay any taxes or assessments upon any project or any property or upon any operation of the Authority or the income therefrom, or any taxes or assessments upon any project or any property or local obligation acquired or used by the Authority under the provisions of this chapter or upon the income therefrom. The exemptions hereby granted shall not extend to persons or entities conducting on the Authority's property businesses for which payment of state or local taxes would otherwise be required.

§ 38.2-6420. Employees of Authority.

A. Employees of the Authority, including the Executive Director:

1. May not be individuals who are simultaneously an insurance agent or broker, an employee of, a consultant to, a member of a board of directors of, or affiliated with or who have an ownership interest in any health carrier, insurance agency, insurance consultant organization, trade association of health carriers, or association offering health insurance coverage to its members;

2. Shall be paid and receive benefits, as determined by the Board, solely from grants or assessments; and

3. Shall be eligible for membership in the Virginia Retirement System and participation in all of the health and related insurance and other benefits, including premium conversion and flexible benefits, available to state employees as provided by law.

B. The provisions of the Virginia Personnel Act (§ 2.2-2900 et seq.) and the Workforce Transition Act (§ 2.2-3200 et seq.) shall not apply to the Authority in the exercise of any power conferred under this chapter. The Board shall develop and adopt policies and procedures that will afford its employees grievance rights, ensure that employment decisions shall be based upon the merit and fitness of applicants, and shall prohibit discrimination because of race, religion, color, sex, or national origin.

C. No employee of the Authority in performing duties related to the operation of the Exchange shall be required to be licensed by the Commission as an insurance agent.

D. No employee of the Authority shall, for one year after terminating employment with the Authority, accept employment with any health carrier that offers a qualified health benefit plan through the Exchange.

§ 38.2-6421. Exemption of Authority from Virginia Public Procurement Act.

The provisions of the Virginia Public Procurement Act (§ 2.2-4300 et seq.) shall not apply to the Authority in the exercise of any power conferred under this chapter; however, the Board shall adopt regulations relative to procurement that include standards of ethics for procurement consistent with the provisions of Article 6 (§ 2.2-4367 et seq.) of Chapter 43 of Title 2.2 and that ensure that Authority procurement will be based on competitive principles.

§ 38.2-6422. Exemption of Authority from Administrative Process Act; rules of practice and procedure.

A. The provisions of the Administrative Process Act (§ 2.2-4000 et seq.) shall not apply to the Authority in the exercise of any power conferred under this chapter.

B. The Authority shall prescribe its own rules of practice and procedure not inconsistent with the rules of practice and procedure adopted by the Commission pursuant to § 12.1-25. Such rules shall be printed and entered upon the records of the Authority and be available on the Authority's website. Copies of such rules shall be furnished to any citizen of the Commonwealth who makes application therefor.

§ 38.2-6423. Regulations; adoption procedures.

A. The Authority shall have the power to adopt, amend, and repeal regulations, not inconsistent with this chapter or other applicable laws, to carry into effect the powers and purposes of the Authority and the establishment and operation of the Exchange. Such regulations shall be designed to effectuate the general purposes of this chapter.

B. The full text of any proposed new regulation or any amendment to or repeal of a regulation shall be published not less than 15 nor more than 30 days before the same may be acted upon and shall state the time and place of a public hearing at which the matters mentioned therein will be considered, at which time any person wishing to comment shall be heard and any written comment shall be considered. Such publication shall be in the Virginia Register of Regulations and in addition, as the Exchange may determine, may be similarly published in newspapers as well as publicized through press releases and other media as will best serve the purpose and subject involved.

C. If the Exchange is satisfied that the proposed regulation or amendments thereto or repeal thereof, or any part thereof, in the form in which it was proposed or changed as a result of such public hearing, provided the changes do not alter the main purpose of the regulation, is advisable, such regulation, amendment to, or repeal of a regulation, or any part thereof, may be adopted and, if adopted, shall be published in the Virginia Register of Regulations and the Virginia Administrative Code and shall state the date when it is to become effective.

§ 38.2-6424. Sovereign immunity.

No provisions of this chapter nor act of the Authority, including the procurement of insurance or self-insurance, shall be deemed a waiver of any sovereign immunity to which the Authority or its directors, officers, employees, or agents are otherwise entitled.

§ 38.2-6425. Reports.

A. The Authority shall submit an annual report to the Governor, the Chairmen of the House and Senate Commerce and Labor Committees, and the Chairmen of the House Appropriations Committee and Senate Finance Committee within 90 days from the end of its fiscal year. Such report shall contain the audited annual financial statements of the Authority for the year ending the previous June 30.

B. Each annual report of the Authority shall include:

1. A description of the effect of adverse selection on the operations of the Exchange and shall make legislative recommendations, if necessary, to reduce the negative impact from any such adverse selection on the sustainability of the Exchange, including recommendations to ensure that regulation of health carriers and health benefit plans are similar for qualified health plans offered through the Exchange and health benefit plans offered outside the Exchange. The Authority shall evaluate whether adverse selection is occurring with respect to health benefit plans that are grandfathered under the Federal Act, self-insured plans, plans sold through the Exchange, and plans sold outside the Exchange;

2. A report on administrative expenses so that fees assessed pursuant to § 38.2-6412 are accurately reflected in the operation of the Authority;

3. A description of its operations and accomplishments;

4. A statement of its receipts and expenditures during such fiscal year, including the accounting described in subdivision 19 of § 38.2-6409; and

5. A statement of its assets and liabilities at the end of its fiscal year, including a schedule of its reserve, special, and other funds.

§ 38.2-6426. Documentation requirements; use of information by the Authority.

A. The Authority shall adopt regulations setting forth the information that shall be documented in order for an individual to qualify for (i) health plan coverage through the Exchange, (ii) premium tax credits, and (iii) cost-sharing reductions. The documentation specified by the Authority under this subsection shall include but is not limited to documentation of:

1. The identity of the individual;

2. The status of the individual as a United States citizen, or lawfully admitted noncitizen, and a resident of the Commonwealth;

3. Information concerning the income and resources of the individual as necessary to establish the individual's financial eligibility for coverage, for premium tax credits and for cost-sharing reductions,

which may include income tax return information and a social security number; and

4. Employer identification information and employer-sponsored health insurance coverage information applicable to the individual.

B. The Authority shall adopt regulations regarding the information that is required to be documented in order to determine whether the individual is exempt from a requirement to purchase or be enrolled in a health plan under 26 U.S.C. § 5000A or other federal law.

C. The Authority shall implement systems that provide electronic access to and use, disclosure, and validation of data needed to administer the duties, functions, and operation of the Authority, to comply with federal data access and data exchange requirements and to streamline and simplify processes of the Exchange.

D. Information and data that the Authority obtains under this section may be exchanged with other state or federal health insurance exchanges and with state or federal agencies for the purpose of carrying out Exchange responsibilities, which responsibilities include but are not limited to:

1. Establishing and verifying eligibility for (i) a state medical assistance program, (ii) the purchase of health plans through the Exchange, and (iii) any other programs that are offered through the Exchange;

2. Establishing and verifying the amount of an individual's federal tax credit, cost-sharing reduction, or premium assistance;

3. Establishing and verifying eligibility for exemption from the requirement to purchase or be enrolled in a health plan under 26 U.S.C. § 5000A or other federal law;

4. Complying with other federal requirements; and

5. Improving the operations of the Exchange and other programs administered by the Authority and for program analysis.

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

§ 38.2-6427. Navigators.

A. The Authority shall establish a Navigator program that shall award grants to certain entities to market the Exchange for the purposes of (i) conducting public education activities to raise awareness of the availability of qualified health plans and state medical assistance programs; (ii) distributing fair and impartial information concerning enrollment in qualified health plans and state medical assistance programs; (iii) distributing fair and impartial information about the availability of premium assistance tax credits and cost-sharing reductions pursuant to the Federal Act; (iv) facilitating enrollment in qualified health plans; (v) providing referrals to the health insurance ombudsman established under Section 2793 of the Public Health Service Act, 42 U.S.C. § 300gg-93, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding the enrollee's health benefit plan, coverage, or a determination under that plan or coverage; and (vi) providing information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.

B. The Authority shall award Navigator grants, at the sole discretion of the Board, to community-based organizations and to any of the following entities to carry out Navigator functions:

1. Consumer-focused nonprofit groups;

2. Trade, industry, and professional associations;

3. Commercial fishing industry, ranching, and farming organizations;

4. Chambers of commerce;

5. Unions;

6. Licensed agents and brokers; and

7. Other public or private entities that meet the requirements of this section, including Indian tribes, tribal organizations, urban Indian organizations, and state or local social service agencies.

C. The Exchange shall ensure that a Navigator shall not (i) be a health insurance issuer or (ii) receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a qualified health plan.

D. An entity that serves as a Navigator shall carry out at least the following duties:

1. Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange;

2. Provide information and services in a fair, accurate, and impartial manner. Such information must acknowledge other health programs;

3. Facilitate enrollment in qualified health plans and state medical assistance programs;

4. Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under § 2793 of the federal Public Health Service Act, 42 U.S.C. § 254, or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint,

or question regarding his health plan, coverage, or a determination under such plan or coverage; and

5. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with applicable law.

E. Funding for Navigator grants may not be from federal funds received by the Commonwealth to establish the Exchange.

F. The Exchange shall offer appropriate education to Navigators, agents, and brokers and community-based organizations, but licensure shall not be required.

§ 38.2-6428. False or misleading filings; civil penalties.

A. Any person who files or causes to be filed with the Authority any article, certificate, report, statement, application, or any other information required or permitted to be filed, that is known by the person to be false or misleading in any material respect, or willfully and knowingly violates any provision of this chapter, or any rule, regulation or order issued under this chapter, shall be subject to a civil penalty, to be determined and assessed by the Board, of not more than $5,000.

B. All civil penalties recovered under subsection A shall be paid to the Authority to the credit of a special fund established pursuant to subsection C of § 38.2-6412.

§ 38.2-6429. Operation of the Exchange.

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 employees may choose or designate a level of coverage to be made available to employees though the Exchange.

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

C. The Exchange shall not combine actuarial and underwriting functions for the American Health Benefit Exchange and the SHOP exchange, and shall keep intact a separate and distinct risk pool for the individual market and the small group market. In accordance with § 1312(c) of the Federal Act, a health carrier shall consider:

1. All enrollees in all health benefit plans, other than grandfathered health plans, offered by the health carrier in the individual market, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool; and

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

D. This chapter shall not prohibit (i) a health carrier from offering outside of the Exchange a health benefit plan to a qualified individual or qualified employer, provided that the health benefit plan is offered within the Exchange at the same premium rate, or (ii) a qualified individual from enrolling in and a qualified employer from selecting for its employees a health benefit plan offered outside of the Exchange, provided that the health benefit plan is offered within the Exchange at the same premium rate.

§ 38.2-6430. Application to health benefit plans marketed outside the Exchange.

The provisions of this chapter and regulations enacted pursuant thereto shall apply to the marketing, offering for sale, or sale of health benefit plans in the Commonwealth outside of the Exchange to the extent provided in this chapter and in §§ 38.2-316, 38.2-3510.1, 38.2-3518, 38.2-3522.1, and 38.2-3523.4.

§ 38.2-6431. Relation to other laws.

Except as expressly provided to the contrary in this chapter, all health carriers offering qualified health plans in the Commonwealth shall comply fully with all applicable health insurance laws of the Commonwealth.

§ 63.2-206. Cooperation with federal and state agencies; establishment and operation of health benefit exchange.

A. The Commissioner shall cooperate with the Department of Health and Human Services and other agencies of the United States and with the local boards, in relation to matters set forth in this title, and in any reasonable manner that may be necessary for this Commonwealth to qualify for and to receive grants or aid from such federal agencies for public assistance and services in conformity with the provisions of this title, including grants or aid to assist in providing rehabilitation and other services to help individuals to attain or retain capability for self-care or self-support and such services as are likely to prevent or reduce dependency and, in the case of dependent children, to maintain and strengthen family life. The Commissioner shall make such reports in such form and containing information as such agencies of the United States may require and shall comply with such provisions as such agencies require to assure the correctness and verification of such reports.

B. In addition to other duties imposed upon the Department pursuant to this title, the Department shall assist the Virginia Health Benefit Exchange Authority in its implementation of the provisions of Chapter 64 (§ 38.2-6400 et seq.) of Title 38.2 by:

1. Entering into one or more agreements, as described in § 38.2-6417, with the Authority, the State Corporation Commission, the Department of Medical Assistance Services, or the Department of Health, which agreements shall provide for compensation of the Department by the Authority for expenses incurred in performing its obligations thereunder; and

2. Performing such other tasks relating to the establishment and operation of the Virginia Exchange as are provided in an agreement entered into pursuant to subdivision 1 or as are required in order to assist the Authority in complying with the applicable requirements of the Federal Act, as such term is defined in § 38.2-6401, that pertain to programs and functions of the Department.

2. That the State Corporation Commission shall conduct proceedings pursuant to its Rules of Practice and Procedure to adopt regulations that enable the Commission to perform its duties under this act or duties that it agrees to perform pursuant to any agreement with the Virginia Health Benefit Exchange Authority created pursuant to this act.

3. That the requirement that the Commonwealth establish a health benefit exchange in accordance with the provisions of the 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, shall be deemed to be a public health emergency situation pursuant to § 2.2-4011 of the Code of Virginia; therefore, to meet this emergency situation, the board of directors of the Virginia Health Benefit Exchange Authority shall promulgate emergency regulations to implement this act.

4. That the provisions of this act shall expire on the effective date of (i) a final, nonappealable order of a court of proper jurisdiction invalidating the 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, or (ii) federal legislation repealing such Act.