12100906D

SENATE BILL NO. 496

Offered January 11, 2012

Prefiled January 11, 2012

A BILL to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6415, relating to the establishment and operation of a health benefit exchange for the Commonwealth; assessments.

Patron—Watkins

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

1. That the Code of Virginia is amended by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6415, as follows:

CHAPTER 64.

VIRGINIA HEALTH BENEFIT EXCHANGE.

§ 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:

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

"Benchmark health insurance plan" is the largest plan, measured by enrollment, in the largest product in the Commonwealth's small group market, as determined by the Exchange.

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

"Committee" means the advisory committee appointed by the Commission pursuant to § 38.2-6404.

"Director" means the director of the Division appointed by the Commission pursuant to § 38.2-6403.

"Division" means the Health Benefit Exchange Division, an administrative division of the Commission.

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

"Essential health benefits" or "EHB" means the items and services included in the benchmark health insurance plan, as supplemented by the Exchange in order to provide coverage for the items and services within the statutory EHB categories.

"Essential health benefits package" means, with respect to any health benefit plan, coverage that (i) provides the essential health benefits with any modifications to coverage within a benefit category that are permitted by the Exchange upon findings that (a) the essential benefits package with such modifications continues to provide coverage for all statutory EHB categories and (b) the modifications do not reduce the value of coverage of the health plan, (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 Division or (ii) the Virginia Health Benefit Exchange established pursuant to the provisions of this chapter and in accordance with 1311(b) of the Federal Act, through which qualified health plans and qualified dental plans are made available to qualified individuals through the American Health Benefit Exchange and to qualified employers through the SHOP exchange. "Exchange," when referring to the Virginia Health Benefit Exchange, collectively refers to both the American Health Benefit Exchange and the SHOP exchange.

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

"Health benefit plan" or "plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. The term does not include coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for onsite

medical clinics; or other similar insurance coverage, specified in federal regulations issued pursuant to the Federal Act, under which benefits for medical care are secondary or incidental to other insurance benefits. The term does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar limited benefits specified in federal regulations issued pursuant to the Federal Act. The term does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness, for hospital indemnity, or other fixed indemnity insurance. The term does not include the following if offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under § 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.

"Navigator" means a public or private entity or individual that is qualified and licensed to provide information on or enroll qualified individuals in a qualified health plan.

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

"Qualified dental plan" means a limited scope dental plan that has been certified in accordance with § 38.2-6407.

"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 or qualified dental 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 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.

"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 § 38.2-6407.

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

"Secretary" means the Secretary of the 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 or qualified dental 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 or qualified dental 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.

"Statutory EHB categories" means:

1. Ambulatory patient services;

2. Emergency services;

3. Hospitalization;

4. Maternity and newborn care;

5. Mental health and substance use disorder services, including behavioral health treatment;

6. Prescription drugs;

7. Rehabilitative and habilitative services and devices;

8. Laboratory services;

9. Preventive and wellness services and chronic disease management; and

10. Pediatric services, including oral and vision care.

§ 38.2-6402. Purpose.

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

§ 38.2-6403. Division established; Exchange created.

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

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

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

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

§ 38.2-6404. Advisory committee.

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

B. The Commissioner of Insurance, the Director of the Department of Medical Assistance Services, and the Virginia Secretary of Health and Human Resources shall serve as ex officio nonvoting members

of the Committee. An ex officio member may designate a representative to serve in his place.

C. Members of the Committee shall not be a legislator or hold any elective office in state government.

§ 38.2-6405. Exchange requirements.

A. The Exchange shall make qualified health plans and qualified dental plans available to qualified individuals and qualified employers beginning with effective dates on January 1, 2014. The Exchange shall not make available any health benefit plan that is not a qualified health plan. The Exchange shall allow a health carrier to offer a qualified dental plan either separately or in conjunction with a qualified health plan.

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

C. The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of § 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, 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.

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

E. Any person who acts on behalf of an Exchange shall act as a fiduciary. Such person shall ensure that the Exchange is operated (i) solely in the interests of qualified individuals and qualified employers participating in qualified health plans offered through the Exchange, and (ii) for the exclusive purpose of facilitating the purchase of qualified health plans. Any person who acts as a fiduciary on behalf of the Exchange who breaches any of their responsibilities, obligations, or duties imposed by this section shall be liable to make good to the Exchange, the qualified health plans offered through the Exchange, or participants of qualified health plans offered through the Exchange, any losses resulting from each breach, and shall be subject to such other legal or equitable relief as the court may deem appropriate, including removal of such fiduciary.

§ 38.2-6406. Duties of Exchange.

The Exchange shall:

1. Implement procedures for the certification, recertification, and decertification of health benefit plans as qualified health plans, consistent with guidelines developed by the Secretary under § 1311(c) of the Federal Act and § 38.2-6407;

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 hot line to respond to requests for assistance;

4. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

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

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

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

8. Inform individuals, in accordance with § 1413 of the Federal Act, of eligibility requirements for 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 an American Health Benefit Exchange, through which qualified individuals may enroll in any qualified plan offered through the American Health Benefit Exchange for which they are eligible, and establish a SHOP exchange through which qualified employers may make its employees eligible for one or more qualified health plans offered through the SHOP Exchange or 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. Subject to § 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under § 5000A of the Internal Revenue Code of 1986, an individual is

exempt from the individual responsibility requirement or from the penalty imposed by that section because there is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual or the individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

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

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

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

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

13. Provide to each employer the name of each of the employer's employees described in subdivision 12 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. 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 to:

a. Conduct public education activities to raise awareness of the availability of qualified health plans;

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

c. Facilitate enrollment in qualified health plans and qualified dental plans;

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

e. Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

16. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

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

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

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

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

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

e. The Department of Medical Assistance Services;

f. Federally recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994 (25 USC §479a), that are located within the Exchange's geographic area;

g. Public health experts;

h. Health care providers;

i. Employers with more than 50 employees;

j. Health insurance issuers; and

k. Insurance agents;

18. Meet the following financial integrity requirements:

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

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

(1). Investigate the affairs of the Exchange;

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

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

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

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

§ 38.2-6407. Certification of health benefit plans as qualified health plans.

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

1. The plan provides the essential health benefits package, except that the plan shall not be required to (i) provide any state-mandated health benefit that is not required by the Federal Act to be provided in the essential health benefits package or (ii) provide essential benefits that duplicate the minimum benefits of qualified dental plans, as set forth in subsection F, if (a) the Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage and (b) the health carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Board, 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 premium rates and contract language have been approved by the Bureau;

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

4. The plan's cost-sharing requirements do not exceed the limits established under § 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP 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 and (ii) one qualified health plan at a gold level of coverage 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 in violation of subsection D of § 38.2-6405; and

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

6. The plan meets the requirements of certification as adopted by regulation adopted pursuant to § 38.2-6411 or promulgated by the Secretary under § 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance.

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

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

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

1. Submit a justification for any premium increase to the Bureau before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by

the Bureau under § 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans 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 Exchange, the Secretary, and the Bureau, accurate and timely disclosure of the following for such plan:

a. Claims payment policies and practices;

b. Periodic financial disclosures;

c. Data on enrollment;

d. Data on disenrollment;

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

f. Data on rating practices;

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

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

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

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

E. The Exchange 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.

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

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

2. Qualified dental plans shall be limited to dental and oral health benefits, without substantial duplication of the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the 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. An issuer may jointly offer through the Exchange a qualified dental plan and a qualified health plan, provided the plans are priced separately and are also made available for purchase separately Nothing in this subsection shall be construed as prohibiting carriers from offering a discounted rate on a qualified dental plan when purchased jointly with a qualified health plan.

G. The Exchange shall ensure that no qualified health insurance plan that is sold or offered for sale through the Exchange shall provide coverage for abortions, regardless of whether such coverage is provided through the plan or is offered as a separate optional rider thereto. This limitation shall not apply to an abortion performed (i) when the life of the mother is endangered by a physical disorder, physical illness, or physical injury, including a life-endangering physical condition caused by or arising from the pregnancy itself, or (ii) when the pregnancy is the result of an alleged act of rape or incest.

§ 38.2-6408. Appeal of decertification or denial of certification.

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

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

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

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

C. Any hearing held pursuant to subsection B shall be conducted by an impartial party or an administrative law judge with appropriate legal training and in accordance with the hearing requirements of the Administrative Process Act (§ 2.2-4000 et seq.).

§ 38.2-6409. Open enrollment periods.

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

§ 38.2-6410. Choice; risk pooling.

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

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

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

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

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

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

1. This section shall not prohibit:

a. A health carrier from offering outside of an Exchange a health plan to a qualified individual or qualified employer; or

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

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

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

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

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

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

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

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

§ 38.2-6411. Funding; publication of costs.

A. The Exchange shall be authorized to fund its operations through special fund revenues generated by assessment fees on health carriers that sell through the Exchange, funds described in subsection E, or such funds as the General Assembly may from time to time appropriate.

B. The Exchange shall have funding from the sources described in subsection A in an amount sufficient to support its ongoing operations beginning not later than January 1, 2015. Charges assessed shall be reasonable and necessary to support the development, operations, and prudent cash management of the Exchange. Assessments and fee schedules shall be approved by the Commission prior to implementation.

C. Any assessments or fees charged to carriers are limited to the minimum amount necessary to pay for the administrative costs and expenses that have been approved in the annual budget process, after consideration of other available funding. Services performed by the Exchange on behalf of other state or federal programs shall not be funded with assessments or user fees collected from health carriers. Any unspent funding by an Exchange shall be used for future state operation of its Exchange or returned to health carriers as a credit if a state charges fees to carriers.

D. Taxes, fees or assessments used to finance the Exchange shall be clearly disclosed by the Exchange as such, including publishing the average cost of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs.

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

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

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

the Exchange.

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

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

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

§ 38.2-6412. Procurement, contracting, and personnel.

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

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

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

§ 38.2-6413. Confidentiality.

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

B. The Exchange may enter into information-sharing agreements with federal and state agencies and other states' health benefit exchanges to carry out its responsibilities under this chapter, provided 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.

§ 38.2-6414. Regulations.

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

§ 38.2-6415. Relation to other laws.

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

2. That by December 1, 2012, the State Corporation Commission shall submit to the Governor and the General Assembly a report that includes a proposed budget for the Exchange established pursuant to this act. The report shall identify a funding mechanism that the Commission proposes to use to fund the Exchange, which mechanism shall be sufficient to cover the costs of operating the Exchange commencing January 1, 2015.

3. That this act shall be construed as inseparable from Title I, subtitle D of the Patient Protection and Affordable Care Act, Pub. L. 111-148, and if any section, clause, provision, or portion of Title I, subtitle D of the Patient Protection and Affordable Care Act shall be repealed, or held invalid or unconstitutional by any court of competent jurisdiction, this act shall expire on the effective date of such repeal or final nonappealable court order.