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SENATE BILL NO. 1363

Offered January 20, 2015

A *BILL to amend and reenact §§ 38.2-4214, 38.2-4319, and 38.2-4509 of the Code of Virginia; to amend the Code of Virginia by adding in Title 38.2 a chapter numbered 64, consisting of sections numbered 38.2-6400 through 38.2-6415; and to repeal the second enactments of Chapters 670 and 679 of the Acts of Assembly of 2013, relating to the establishment and operation of a health benefit exchange for the Commonwealth; assessments.*

Patrons—Alexander and Watkins

Referred to Committee on Commerce and Labor

Be it enacted by the General Assembly of Virginia:

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

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

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

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

A. No provisions of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-100, 38.2-136, 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-216, 38.2-218 through 38.2-225, 38.2-229, 38.2-232, 38.2-305, 38.2-316, 38.2-316.1, 38.2-322, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 5.1 (§ 38.2-1334.3 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3405, 38.2-3405.1, 38.2-3406.1, 38.2-3407.2 through 38.2-3407.6:1, 38.2-3407.9 through 38.2-3407.18, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1:01, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.17, 38.2-3419.1, 38.2-3430.1 through 38.2-3454, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), and Chapter 58 (§ 38.2-5800 et seq.), and Chapter 64 (§ 38.2-6400 et seq.) shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

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

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SB1363

seq.), 5 (§ 38.2-1322 et seq.), and 5.1 (§ 38.2-1334.3 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.) and 2 (§ 38.2-1412 et seq.) of Chapter 14, §§ 38.2-3401, 38.2-3405, 38.2-3407.2 through 38.2-3407.5, 38.2-3407.6, 38.2-3407.6:1, 38.2-3407.9, 38.2-3407.9:01, and 38.2-3407.9:02, subdivisions F 1, F 2, and F 3 of § 38.2-3407.10, §§ 38.2-3407.11, 38.2-3407.11:3, 38.2-3407.13, 38.2-3407.13:1, 38.2-3407.14, 38.2-3411.2, 38.2-3418.1, 38.2-3418.2, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, 38.2-3500, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1, 38.2-3514.2, 38.2-3522.1 through 38.2-3523.4, 38.2-3525, 38.2-3540.1, 38.2-3540.2, 38.2-3541.2, 38.2-3542, 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.), *and Chapter 64 (§ 38.2-6400 et seq.)* shall be applicable to any health maintenance organization granted a license under this chapter. This chapter shall not apply to an insurer or health services plan licensed and regulated in conformance with the insurance laws or Chapter 42 (§ 38.2-4200 et seq.) except with respect to the activities of its health maintenance organization.

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

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

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

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

§ 38.2-4509. Application of certain laws.

A. No provision of this title except this chapter and, insofar as they are not inconsistent with this chapter, §§ 38.2-200, 38.2-203, 38.2-209 through 38.2-213, 38.2-218 through 38.2-225, 38.2-229, 38.2-316, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-620, 38.2-900 through 38.2-904, 38.2-1038, 38.2-1040 through 38.2-1044, Articles 1 (§ 38.2-1300 et seq.) and 2 (§ 38.2-1306.2 et seq.) of Chapter 13, §§ 38.2-1312, 38.2-1314, 38.2-1315.1, Articles 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), and 6 (§ 38.2-1335 et seq.) of Chapter 13, §§ 38.2-1400 through 38.2-1444, 38.2-1800 through 38.2-1836, 38.2-3401, 38.2-3404, 38.2-3405, 38.2-3407.1, 38.2-3407.4, 38.2-3407.10, 38.2-3407.13, 38.2-3407.14, 38.2-3407.15, 38.2-3407.17, 38.2-3415, 38.2-3541, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, §§ 38.2-3600 through 38.2-3603, Chapter 55 (§ 38.2-5500 et seq.), ~~and~~ Chapter 58 (§ 38.2-5800 et seq.), *and Chapter 64 (§ 38.2-6400 et seq.)* shall apply to the operation of a plan.

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

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

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

CHAPTER 64.

VIRGINIA HEALTH BENEFIT EXCHANGE.

§ 38.2-6400. Definitions.

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

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

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

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

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

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

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

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

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

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

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

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

"Health benefit plan" or "plan" means a policy, contract, certificate, or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. The term does not include coverage only for accident or disability income insurance, or any combination thereof; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for onsite medical clinics; or other similar insurance coverage, specified in federal regulations issued pursuant to the Federal Act, under which benefits for medical care are secondary or incidental to other insurance benefits. The term does not include the following benefits if they are provided under a separate policy, certificate, or contract of insurance or are otherwise not an integral part of the plan: limited scope dental or vision benefits; benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or other similar limited benefits specified in federal regulations issued pursuant to the Federal Act. The term does not include the following benefits if the benefits are provided under a separate policy, certificate, or contract of insurance; there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor: coverage only for a specified disease or illness, for hospital indemnity, or other fixed indemnity insurance. The term does not include the following if offered as a separate policy, certificate, or contract of insurance: Medicare supplemental health insurance as defined under § 1882(g)(1) of the U.S. Social Security Act; coverage supplemental to the coverage provided under 10 U.S.C. § 1071 et seq. (TRICARE); or similar supplemental coverage provided under a group health plan.

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

"Minimum essential coverage" means the standardized set of essential health benefits that is required to be met by a qualified health plan or qualified dental plan or other health insurance issuer as required by 45 C.F.R. § 147.150.

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

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

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

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

employed, or (ii) elects to provide coverage through the SHOP exchange to all of its eligible employees who are principally employed in the Commonwealth.

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

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

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

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

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

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

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

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

§ 38.2-6401. Exchange objectives.

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

§ 38.2-6402. 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 shall have overall management responsibility for the Exchange.

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

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

E. Notwithstanding any provision of subsection A to the contrary, the Secretary of Health and Human Resources shall be responsible for (i) providing technology infrastructure development and implementation thereof; (ii) providing ongoing technology support services and maintenance of core information systems platforms, including website development and maintenance; (iii) managing the procurement of technology hardware, software, and technology services, other than personal computers, laptops, and other equipment, used by the Exchange to carry out its functions; and (iv) providing the Commission with secured access to the system functions for eligibility and enrollment, plan administration, customer service, financial management, and marketing, outreach, and education. The Virginia Secretary of Health and Human Resources shall bill the Commission for access to such systems based on fair and reasonable billing rates.

§ 38.2-6403. Advisory Committee.

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

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

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

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

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

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

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

§ 38.2-6404. Exchange requirements.

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

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

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

D. Neither the Exchange nor a carrier offering 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.

§ 38.2-6405. Duties of Exchange.

The Exchange shall:

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

305 of the Federal Act and § 38.2-6406;

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

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

308 4. Utilize a website developed and maintained by the Virginia Secretary of Health and Human
309 Resources on which enrollees and prospective enrollees of qualified health plans may obtain
310 standardized comparative information on such plans, including, at a minimum, (i) premium and
311 cost-sharing information; (ii) the summary of benefits and coverage offered; (iii) identification of a
312 qualified health plan as a bronze-level, silver-level, gold-level, or platinum-level plan as defined by
313 § 1302(d) of the Federal Act or a catastrophic plan as defined by § 1302(e) of the Federal Act; (iv) the
314 results of enrollee satisfaction surveys, described in § 1311(c)(4) of the Federal Act; (v) quality ratings
315 assigned pursuant to § 1311(c)(3) of the Federal Act; (vi) medical loss ratio information as reported to
316 the Secretary in accordance with 45 C.F.R. Part 158; (vii) transparency of coverage measures reported
317 to the Exchange during certification processes; and (viii) the provider directory made available to the
318 Exchange. The website shall be accessible to persons with disabilities, shall provide meaningful access
319 for persons with limited English proficiency, and shall contain the information described in clauses (i)
320 through (viii) without diversion to a website of a carrier;

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

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

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

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

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

335 10. Establish an American Health Benefit Exchange through which qualified individuals may enroll
336 in any qualified health plan or qualified dental plan offered through the American Health Benefit
337 Exchange for which they are eligible and establish a SHOP exchange through which qualified employers
338 may make their eligible employees eligible for one or more qualified health plans or qualified dental
339 plans offered through the SHOP Exchange or specify a level of coverage so that any of their eligible
340 employees may enroll in any qualified health plan or qualified dental plan offered through the SHOP
341 exchange at the specified level of coverage;

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

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

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

351 b. The name and taxpayer identification number of each individual who was an employee of an
352 employer but who was determined to be eligible for the premium assistance tax credit under 26 U.S.C.
353 § 36B because (i) the employer did not provide minimum essential coverage or (ii) the employer
354 provided minimum essential coverage but a determination under 26 U.S.C. § 36B(c)(2)(C) found that
355 either the coverage was unaffordable for the employee or did not provide the required minimum
356 actuarial value; and

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

361 13. Provide to each employer the name of each of the employer's employees described in subdivision
362 12 b who ceases coverage under a qualified health plan during a plan year and the effective date of the
363 cessation;

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

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

16. Review the rate of premium growth within the 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:

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

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

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

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

e. The Department of Medical Assistance Services;

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

g. Public health experts;

h. Health care providers;

i. Large employers;

j. Health carriers; and

k. Insurance agents;

18. Meet the following financial integrity requirements:

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

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

(1) Investigate the affairs of the 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.

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

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

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

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

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

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

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

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

6. The plan meets the requirements of certification as adopted by regulation pursuant to § 38.2-6414 or promulgated by the Secretary under § 1311(c) of the Federal Act, which include minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms, and descriptions of coverage and information on quality measures for health benefit plan performance.

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

C. In order to foster a competitive marketplace and consumer choice, it is presumed to be in the interest of qualified individuals and qualified employers for the Exchange to, and the Exchange shall, certify all health benefit 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 if it is determined that it is not in the public interest to permit such plans to be offered through the Exchange.

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

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 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 the Exchange's website and through other means for individuals without access to the Internet.

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

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

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

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

3. Participants in the Exchange shall have the option to purchase at least the pediatric dental benefit component of the essential health benefits package either through a separate qualified dental plan or as a part of a combined offer by a qualified health plan, provided that, with respect to a combined offer, the health and dental benefits are priced separately and also made available for purchase separately at the same price.

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

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

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

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

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

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

§ 38.2-6408. 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.

§ 38.2-6409. Choice; risk pooling.

A. In accordance with § 1312(f)(2)(A) of the Federal Act, a qualified employer may either designate one or more qualified health plans from which its eligible employees may choose or designate any level of coverage to be made available to eligible employees through 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 benefit plans, other than grandfathered health benefit plans, offered by such carrier in the individual market, including those enrollees who do not enroll in such plans through the American Health Benefit Exchange, to be members of a single risk pool; and

2. A health carrier shall consider all enrollees in all health benefit plans, other than grandfathered health benefit plans, offered by such carrier in the small group market, including those enrollees who do not enroll in such plans through the SHOP 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 benefit plan to a qualified individual or qualified employer; or

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

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

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:

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.

§ 38.2-6410. Funding; publication of costs.

A. The Exchange shall be authorized to fund its operations through (i) special fund revenues generated by assessment fees on all health carriers, including carriers offering plans through the Exchange and outside the Exchange, (ii) funds described in subsection I, or (iii) 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

551 sufficient to support its ongoing operations beginning not later than the January 1 that follows the date
552 the Exchange begins making qualified health plans and qualified dental plans available to qualified
553 individuals and qualified employers.

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

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

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

572 F. The Exchange shall publish the average costs of licensing, regulatory fees, and any other
573 payments required by the Exchange, and the administrative costs of the Exchange, on an Exchange
574 website in order to educate consumers on such costs. This information shall include information on
575 moneys lost to waste, fraud, and abuse.

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

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

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

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

589 **§ 38.2-6411. Procurement, contracting, and personnel.**

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

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

596 C. Employees of the Exchange shall be (i) exempt from application of the Virginia Personnel Act
597 (§ 2.2-2900 et seq.) and Chapter 30 (§ 2.2-3000 et seq.) of Title 2.2, as hereinafter amended or
598 recodified, to the same extent as other employees of the Commission; (ii) eligible for participation in the
599 Virginia Retirement System to the same extent as other similarly situated employees of the Commission;
600 and (iii) compensated and managed in accordance with the Commission's practices and policies
601 applicable to all Commission employees.

602 **§ 38.2-6412. Confidentiality.**

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

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

such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all state and federal laws and regulations.

§ 38.2-6413. Navigators.

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

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

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

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

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

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

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

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

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

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

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

2. Meet the standards described in subsection F; and

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

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

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

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

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

§ 38.2-6414. Regulations.

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

§ 38.2-6415. Relation to other laws.

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

674 2. That the second enactments of Chapters 670 and 679 of the Acts of Assembly of 2013 are
675 repealed.
676 3. That the provisions of this act shall become effective 60 days after the date that the U.S.
677 Supreme Court issues an opinion in *King v. Burwell*, 759 F.3d 358 (4th Cir. 2014), cert. granted,
678 2014 U.S. LEXIS 7428 (November 7, 2014) (No. 14-114), that reverses the decision of the Fourth
679 Circuit Court of Appeals in that case or otherwise invalidates U.S. Treasury regulation 26 C.F.R.
680 § 1.36B-2(a)(1) and finds that federal premium assistance tax credits or other cost-sharing
681 mechanisms provided pursuant to § 36B of the Patient Protection and Affordable Care Act, P.L.
682 111-148, as amended (the Act), are not available with regard to health insurance policies
683 purchased through a health benefit exchange established by the federal government under § 1321
684 of the Act.