VIRGINIA ACTS OF ASSEMBLY — CHAPTER

An Act to amend and reenact § 38.2-6505 of the Code of Virginia, relating to the Virginia Health Benefit Exchange; marketing.

[H 312]

Approved

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-6505 of the Code of Virginia is amended and reenacted as follows:

§ 38.2-6505. Duties of Exchange.

The Exchange shall:

1. Implement procedures for the certification, recertification, and decertification of qualified health plans and qualified dental plans consistent with guidelines developed by the Secretary under § 1311(c) of the Federal Act and § 38.2-6506;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

15. Certify entities qualified to serve as Navigators in accordance with § 1311(i) of the Federal Act and § 38.2-6513;

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

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

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

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

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

e. The Department of Medical Assistance Services;

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

g. Public health experts;

h. Health care providers;

i. Large employers;

j. Health carriers; and

k. Insurance agents;

17. Meet the following financial integrity requirements:

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

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

(1) Investigate the affairs of the Exchange;

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

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

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

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

19. Identify systems, policies, and practices to achieve the requirements of subdivisions 8 and 18 and in doing so, consult with stakeholders, including the Department of Taxation, the Department of Medical Assistance Services, the Department of Social Services, consumer groups, insurers, health care providers, navigators or other consumer assisters, insurance brokers or agents, and other relevant stakeholders selected by the Exchange; ~~and~~

20. *Prepare an annual marketing plan that includes consumer outreach, licensed health insurance agents, and navigator programs; and*

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