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HOUSE BILL NO. 2332

Offered January 22, 2021

A BILL to amend and reenact §§ 38.2-4214 and 38.2-4319 of the Code of Virginia and to amend the Code of Virginia by adding in Chapter 34 of Title 38.2 an article numbered 10, consisting of sections numbered 38.2-3471 through 38.2-3479, relating to the Commonwealth Health Reinsurance Program; established; special fund established; federal waiver application.

Patrons—Sickles, Helmer, Levine, Price, Rasoul, Subramanyam and Tran; Senators: Favola and Surovell

Referred to Committee on Labor and Commerce

Be it enacted by the General Assembly of Virginia:

1. That §§ 38.2-4214 and 38.2-4319 of the Code of Virginia are amended and reenacted and that the Code of Virginia is amended by adding in Chapter 34 of Title 38.2 an article numbered 10, consisting of sections numbered 38.2-3471 through 38.2-3479, as follows:

Article 10.

Commonwealth Health Reinsurance Program.

§ 38.2-3471. Definitions.

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

"Affordable Care Act" means the Patient Protection and Affordable Care Act, P.L. 111-148, as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, and as it may be further amended.

"Attachment point" means the threshold amount for claims costs incurred by an eligible health carrier for an enrolled individual's covered benefits in a benefit year, beyond which the claims costs for benefits are eligible for reinsurance payments.

"Benefit year" means the calendar year for which an eligible health carrier contracts or offers to provide a health benefit plan providing individual health insurance coverage through the Exchange.

"Coinsurance rate" means the rate at which claims will be reimbursed by reinsurance payments for claims incurred for an enrolled individual's covered benefits in a benefit year above the attachment point and below the reinsurance cap.

"Covered benefits" or "benefits" means those health care services to which an enrolled individual is entitled under the terms of a health benefit plan.

"Eligible health carrier" means a health carrier that contracts or offers to provide a health benefit plan providing individual health insurance coverage through the Exchange.

"Enrolled individual" means a policyholder, subscriber, enrollee, participant, covered dependent, or other individual covered by a health benefit plan providing individual health insurance coverage.

"Exchange" means the Virginia Health Benefit Exchange established pursuant to Chapter 65 (§ 38.2-6500 et seq.).

"Health benefit plan" means a policy, contract, certificate, or agreement offered by a health carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services.

"Health care services" means services for the diagnosis, prevention, treatment, cure, or relief of a health condition, illness, injury, or disease.

"Health 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 health services plan, or any other entity providing a plan of health insurance, health benefits, or health care services.

"Individual health insurance coverage" means coverage for health care services under a health benefit plan sold in the individual market.

"Individual market" means the market for individual health insurance coverage offered on the Exchange.

"Net written premiums" means premiums earned on health benefit plans delivered or issued for delivery in the Commonwealth, less return premiums and dividends paid or credited to policy or contract holders on the health benefits plan business. "Net written premiums" includes the aggregate premiums earned on the entity's insured large group and individual business related to health benefit plans.

"Program" means the Commonwealth Health Reinsurance Program established pursuant to § 38.2-3473.

"Reinsurance cap" means the upper limit amount for claims costs incurred by an eligible health

carrier for an enrolled individual's covered benefits in a benefit year, over which the claims costs for benefits are no longer eligible for reinsurance payments under the Program.

"Reinsurance payments" means an amount paid by the Commission to an eligible health carrier under the Program.

§ 38.2-3472. State innovation waiver request.

A. The Commissioner shall apply to the U.S. Secretary of Health and Human Services under 42 U.S.C. § 18052 for a state innovation waiver for benefit years beginning January 1, 2023, and future years, to establish a reinsurance program, in accordance with the provisions of this article, to maximize federal pass-through funding for the reinsurance program, and to waive any applicable provisions of the Affordable Care Act.

B. The Commissioner shall submit the waiver application to the U.S. Secretary of Health and Human Services by January 1, 2022. The Commissioner shall make a draft application available for public review and comment by October 1, 2021. The Commissioner may amend the waiver application as necessary to carry out the provisions of this article. The Commissioner shall promptly notify the Chairs of the House Committees on Labor and Commerce and Appropriations and the Senate Committees on Commerce and Labor and Finance and Appropriations of any federal actions regarding the waiver request and of any amendment to the waiver application.

§ 38.2-3473. Commonwealth Health Reinsurance Program; established.

A. Upon approval of the Commissioner's application for a state innovation waiver as required by § 38.2-3472, the Commission shall implement a reinsurance program, known as the Commonwealth Health Reinsurance Program. The purpose of the Program is to stabilize premiums for health benefit plans in the individual market by providing greater affordability for consumers of health insurance in the Commonwealth.

B. The Commission shall perform all functions necessary and appropriate to administer and carry out the operation of the Program and effectuate the purposes of the Program in accordance with the provisions of the waiver and this article.

§ 38.2-3474. Reinsurance parameters.

A. The Commission shall, not less than 20 days before the initial rates and not less than 60 days before final rates for health benefit plans are required to be submitted each year, determine and publish the attachment point, coinsurance rate, and reinsurance cap applicable to the Program for the applicable benefit year.

B. In determining the attachment point, coinsurance rate, and reinsurance cap, the Commission's determination of the attachment point, coinsurance rate, and reinsurance cap shall:

1. Stabilize or reduce premium rates in the individual market;

2. Increase participation in the individual market;

3. Improve access to health care services and their providers for enrolled individuals;

4. Mitigate the impact high-risk individuals have on premium rates in the individual market;

5. Take into account any federal funding available for the Program; and

6. Take into account the total amount available to fund the Program.

§ 38.2-3475. Health Insurance Affordability Special Fund.

A. The Commission shall be authorized to fund the operations of the Program through funds provided to the Commonwealth pursuant to the state innovation waiver requested pursuant to § 38.2-3472, and all funds appropriated for such purpose. All funds received under this section and paid into the state treasury shall be deposited to a special fund designated "Health Insurance Affordability Special Fund State Corporation Commission" (the Fund). Interest earned on moneys in the Fund shall remain in the Fund and be credited to it. Any moneys remaining in the Fund, including interest thereon, at the end of each fiscal year shall not revert to the general fund but shall remain in the Fund. Moneys in the Fund shall be used for (i) the purposes of increasing affordability in the individual market through the Program with a goal of decreasing premiums by up to 20 percent, depending on available revenue, (ii) the purpose of increasing affordability in the individual market through measures identified by the Commission to reduce costs for consumers, (iii) consumer enrollment, outreach, and education activities and (iv) any Program start-up, administrative, or operational costs. Expenditures and disbursements from the Fund shall be made by the State Treasurer on warrants issued by the Comptroller upon written request signed by the Commissioner or his designee.

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

§ 38.2-3476. Calculation of reinsurance payments.

A. Each reinsurance payment shall be calculated with respect to an eligible health carrier's incurred claims costs for an enrolled individual's covered benefits in the applicable benefit year. If such incurred claims costs for an enrolled individual do not exceed the attachment point, the reinsurance payment is

$0. If such incurred claims costs for an enrolled individual exceed the attachment point, the reinsurance payment shall be calculated as the product of the coinsurance rate and the lesser of (i) the claims costs, minus the attachment point, or (ii) the reinsurance cap, minus the attachment point.

B. The Commission shall ensure that reinsurance payments made to eligible health carriers do not exceed the total amount paid for an eligible claim by the eligible health carrier. As used in this subsection, "total amount paid for an eligible claim" means the amount paid by the eligible health carrier, based upon the allowed amount, less any deductible, coinsurance, or copayment, as of the time the data is submitted or made accessible under subsection C of § 38.2-3477.

§ 38.2-3477. Requests for reinsurance payments; data submissions.

A. An eligible health carrier may request reinsurance payments from the Commission when the eligible health carrier meets the requirements of this section and § 38.2-3476.

B. An eligible health carrier's request for reinsurance payments shall comply with any requirements established by the Commission.

C. An eligible health carrier's request for reinsurance payments shall (i) provide the Commission with access to the data within the dedicated data environment established by the eligible health carrier under the federal risk adjustment program under 42 U.S.C. § 18063 and (ii) include an attestation to the Commission asserting compliance with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

D. An eligible health carrier shall provide the access described in subsection C for the applicable benefit year by April 30 of each year of the year following the end of the applicable benefit year.

E. An eligible health carrier shall maintain documents and records, whether paper, electronic, or in other media, sufficient to substantiate the requests for reinsurance payments made pursuant to this article for a period of at least six years. An eligible health carrier shall also make those documents and records available upon request from the Commission for purposes of verification, investigation, audit, or other review of reinsurance payment requests.

F. The Commission may have an eligible health carrier audited to assess the health carrier's compliance with the requirements of this article. The eligible health carrier shall ensure that its contractors, subcontractors, and agents cooperate with any audit conducted under this article. If an audit results in a proposed finding of material weakness or significant deficiency with respect to compliance with any requirement of this article, the eligible health carrier may provide a response to the proposed finding within 30 days. Within 30 days of the issuance of a final audit report that includes a finding of material weakness or significant deficiency, the eligible health carrier shall:

1. Provide a written corrective action plan to the Commission for approval;

2. Implement the approved corrective action plan; and

3. Provide the Commission with written documentation of the corrective action once taken.

§ 38.2-3478. Confidentiality of data.

Data and information that an eligible health carrier considers confidential proprietary information that is provided to the Commission pursuant to the provisions of this article shall be excluded from, and the Commission shall not be subject to, subpoena or public inspection with respect to such information as provided in § 38.2-221.1.

§ 38.2-3479. Accounting and report.

A. The Commission shall keep an accounting for each benefit year of all:

1. Funds appropriated for reinsurance payments and administrative and operational expenses;

2. Requests for reinsurance payments received from eligible health carriers;

3. Reinsurance payments made to eligible health carriers; and

4. Administrative and operational expenses incurred for the Program.

B. By October 15 of each year, the Commission shall report to the House Committees on Labor and Commerce and Appropriations, the Senate Committees on Commerce and Labor and Finance and Appropriations, and the Governor on the operation of the Program. Such report shall be posted on the Commission's website and shall include, at a minimum, the following information for the relevant plan year:

1. Amounts deposited into the Fund;

2. Requests for reinsurance payments received by eligible health carriers;

3. Reinsurance payments made to eligible health carriers;

4. Administrative and operational expenses incurred for the Program; and

5. Quantifiable impact of the Program on individual health insurance coverage rates.

§ 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, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, 38.2-700 through 38.2-705, 38.2-900

through 38.2-904, 38.2-1017, 38.2-1018, 38.2-1038, and 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 38.2-1442, 38.2-1446, 38.2-1447, 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 38.2-3407.20, 38.2-3409, 38.2-3411 through 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) ~~and~~, 9 (§ 38.2-3465 et seq.), *and 10 (§ 38.2-3471 et seq.)* of Chapter 34, §§ 38.2-3501 and 38.2-3502, subdivision 13 of § 38.2-3503, subdivision 8 of § 38.2-3504, §§ 38.2-3514.1 and 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, 38.2-3541.2, 38.2-3542, and 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 and 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and Chapter 65 (§ 38.2-6500 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, 38.2-325, 38.2-326, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 38.2-1306.1, Article 2 (§ 38.2-1306.2 et seq.), § 38.2-1315.1, and Articles 3.1 (§ 38.2-1316.1 et seq.), 4 (§ 38.2-1317 et seq.), 5 (§ 38.2-1322 et seq.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 et seq.) of Chapter 14, Chapter 15 (§ 38.2-1500 et seq.), Chapter 17 (§ 38.2-1700 et seq.), §§ 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 38.2-3407.20, 38.2-3411, 38.2-3411.2, 38.2-3411.3, 38.2-3411.4, 38.2-3412.1, 38.2-3414.1, 38.2-3418.1 through 38.2-3418.20, 38.2-3419.1, and 38.2-3430.1 through 38.2-3454, Articles 8 (§ 38.2-3461 et seq.) ~~and~~, 9 (§ 38.2-3465 et seq.), *and 10 (§ 38.2-3471 et seq.)* of Chapter 34, § 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, and 38.2-3543.2, Article 5 (§ 38.2-3551 et seq.) of Chapter 35, Chapter 35.1 (§ 38.2-3556 et seq.), § 38.2-3610, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.) and Chapter 65 (§ 38.2-6500 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, 38.2-325, 38.2-400, 38.2-402 through 38.2-413, 38.2-500 through 38.2-515, and 38.2-600 through 38.2-629, Chapter 9 (§ 38.2-900 et seq.), §§ 38.2-1016.1 through 38.2-1023, 38.2-1057, and 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.), 5.1 (§ 38.2-1334.3 et seq.), and 5.2 (§ 38.2-1334.11 et seq.) of Chapter 13, Articles 1 (§ 38.2-1400 et seq.), 2 (§ 38.2-1412 et seq.), and 4 (§ 38.2-1446 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, 2, and 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, 38.2-3418.16, 38.2-3419.1, 38.2-3430.1 through 38.2-3437, and 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, and 38.2-3543.2, Chapter 52 (§ 38.2-5200 et seq.), Chapter 55 (§ 38.2-5500 et seq.), Chapter 58 (§ 38.2-5800 et seq.), and Chapter 65 (§ 38.2-6500 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.

2. That the provisions of this act, other than § 38.2-3472 of the Code of Virginia, as created by this act, shall become effective 30 days following the date the Commissioner of Insurance notifies the Governor and the Chairs of the House Committees on Appropriations and Labor and Commerce and the Senate Committees on Finance and Appropriations and Commerce and Labor of federal approval of the state innovation waiver request required to be submitted by the Commissioner of Insurance pursuant to § 38.2-3472 of the Code of Virginia, as created by this act.

3. That the Secretary of Health and Human Resources (the Secretary) shall convene a work group that includes representatives from the State Corporation Commission's Bureau of Insurance and Virginia Health Benefit Exchange Division, the Department of Taxation, health plans, agents and brokers, navigators, other consumer assisters, consumer advocates, and other relevant stakeholders to develop recommendations for developing a state-based subsidy program to increase affordability of health plans to individuals and to increase enrollment in the Virginia Health Benefit Exchange (the Exchange). The work group shall make use of available data pertaining to Exchange enrollment and uninsured individuals to identify recommended options for providing subsidies. In doing so, the work group shall consider implications of a subsidy program on Exchange enrollment and the Commonwealth Health Reinsurance Program, possible tax consequences for individuals, and a feasible timeframe for implementing a subsidy program. The Secretary shall report the work group's recommendations for legislative consideration to the Governor, the Health Benefit Exchange Advisory Committee, and the General Assembly by September 15, 2021.