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HOUSE BILL NO. 2332

FLOOR AMENDMENT IN THE NATURE OF A SUBSTITUTE

(Proposed by Delegate Sickles
on February 4, 2021)

(Patron Prior to Substitute—Delegate Sickles)

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 Title 38.2 a chapter numbered 66, consisting of sections numbered 38.2-6600 through 38.2-6607, relating to the Commonwealth Health Reinsurance Program; established; special fund established; assessment; federal waiver application.

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 Title 38.2 a chapter numbered 66, consisting of sections numbered 38.2-6600 through 38.2-6607, 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, 38.2-325, 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.) 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.), *and Chapter 66 (§ 38.2-6600 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.) 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.), *and Chapter 66 (§ 38.2-6600 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.

CHAPTER 66.

COMMONWEALTH HEALTH REINSURANCE PROGRAM.

§ 38.2-6600. Definitions.

As used in this chapter, 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 amount set by the Commission for claims costs incurred by an eligible carrier for a covered person's covered benefits in a benefit year, above which the claims costs for benefits are eligible for reinsurance payments under the Program.

"Benefit year" means the calendar year for which an eligible carrier provides coverage through an individual health benefit plan.

"Coinsurance rate" means the rate set by the Commission at which the Program will reimburse an eligible carrier for claims incurred for a covered person's covered benefits in a benefit year, which claims exceed the attachment point but are below the reinsurance cap.

"Covered benefits" has the same meaning as provided in § 38.2-3438.

"Covered person" means an individual covered under individual health insurance coverage that (i) is delivered or issued for delivery in the Commonwealth and (ii) is not a grandfathered plan.

"Eligible carrier" means a carrier that (i) offers individual health insurance coverage other than a grandfathered plan and (ii) incurs claims costs for a covered person's covered benefits in the applicable benefit year.

"Fund" means the Commonwealth Health Reinsurance Program Special Fund established by the Commission pursuant to § 38.2-6604.

"Grandfathered plan" has the same meaning as provided in § 38.2-3438.

"Group health insurance coverage" has the same meaning as provided in § 38.2-3438.

"Individual health insurance coverage" has the same meaning as provided in § 38.2-3438.

"Net written premiums" means premiums earned on individual and group health insurance coverage, including grandfathered plans, in the Commonwealth, less return premiums and dividends paid or credited to policy or contract holders on the health benefits plan business.

"Payment parameters" means the attachment point, reinsurance cap, and coinsurance rate for the Program.

"Program" means the Commonwealth Health Reinsurance Program established pursuant to this chapter.

"Reinsurance cap" means the amount set by the Commission for claims costs incurred by an eligible

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

"Reinsurance payment" means an amount paid to an eligible carrier under the Program.

"Total amount paid by the eligible carrier for any eligible claim" means the amount paid by the eligible carrier based on the allowed amount less any deductible, coinsurance, or copayment, as of the time applicable data is submitted or made accessible under subdivision C 1 of § 38.2-6602.

"State Innovation Waiver" means a waiver of one or more requirements of the Affordable Care Act authorized by § 1332 of the Affordable Care Act, 42 U.S.C. § 18052, and applicable federal regulations.

§ 38.2-6601. Commission powers and duties; rules; report.

A. The Commission shall have all the powers necessary to implement the provisions of this chapter and is specifically authorized to:

1. Enter into contracts as necessary or proper to carry out the provisions and purposes of this chapter, including contracts for the administration of the Program and with appropriate administrative staff, consultants, and legal counsel;

2. Take action as necessary to avoid the payment of improper claims under the Program;

3. Establish administrative and accounting procedures for the operation of the Program;

4. Establish procedures and standards for eligible carriers to submit claims under the Program;

5. Establish or adjust the payment parameters in accordance with subdivision B 2 of § 38.2-6602 for each benefit year;

6. Assess special fees for the establishment, administration, and continuous operation of the Program, as provided in § 38.2-6605;

7. Apply for a State Innovation Waiver, federal funds, or both, in accordance with § 38.2-6607, for the implementation and operation of the Program;

8. Apply for, accept, administer, and expend gifts, grants, and donations and any federal funds that become available for the operation of the Program; and

9. Adopt rules as necessary to implement, administer, and enforce this chapter, including rules necessary to align state law with any federal program.

B. If the State Innovation Waiver is granted pursuant to § 38.2-6607, the Commission, during implementation of the Program, shall evaluate the effect of the Program on access to affordable, high-value health insurance for consumers who are eligible for premium tax credit subsidies and cost-sharing reductions.

§ 38.2-6602. Commonwealth Health Reinsurance Program; established.

A. The Commission shall implement a reinsurance program, known as the Commonwealth Health Reinsurance Program. Implementation and operation of the Program is contingent upon approval of the State Innovation Waiver submitted by the Commission in accordance with § 38.2-6607. If the State Innovation Waiver or federal funding request submitted by the Commission pursuant to § 38.2-6607 is approved, the Commission shall implement and operate the Program in accordance with this section.

B. The Commission shall collect or access data from an eligible carrier as necessary to determine reinsurance payments, according to the data requirements under subdivision C 1.

1. On a quarterly basis during the applicable benefit year, (i) each eligible carrier shall report to the Commission its claims costs that exceed the attachment point for that benefit year and (ii) each insurer that is subject to the special fees assessed under § 38.2-6605 shall report to the Commission on its collected assessments related to the special fees assessment in that benefit year. For each applicable benefit year, the Commission shall notify eligible carriers of reinsurance payments to be made for the applicable benefit year no later than September 30 of the year following the applicable benefit year. By November 15 of the year following the applicable benefit year, the Commissioner shall disburse all applicable reinsurance payments to an eligible carrier.

2. For the 2023 benefit year and each benefit year thereafter, the Commissioner shall establish and publish the payment parameters for the applicable benefit year by May 1 of the year immediately preceding the applicable benefit year. In setting the payment parameters under this subsection, the Commission shall consider the following factors: (i) stabilized or reduced premium rates in the individual market; (ii) increased participation in the individual market; (iii) improved access to health care services and their providers for enrolled individuals; (iv) mitigation of the impact high-risk individuals have on premium rates in the individual market; (v) transfers made under the federal risk adjustment program to eliminate double reimbursement for high-cost cases; (vi) the availability of any federal funding available for the Program; and (vii) the total amount available to fund the Program.

3. If the Commission determines that all reinsurance payments requested under the Program by eligible carriers for a benefit year will not be equal to the amount of funding allocated to the Program, the Commission shall determine a uniform pro rata adjustment to be applied to all such requests for reinsurance payments.

C. A carrier that meets the requirement of this subsection and subsection D shall be eligible to

request reinsurance payments from the Program. An eligible carrier shall make requests for reinsurance payments in accordance with the requirements established by the Commission.

1. To receive reinsurance payments through the Program, an eligible carrier shall, by April 30 of the year following the benefit year for which reinsurance payments are requested, (i) provide the Commission with access to the data within the dedicated data environment established by the eligible carrier under the federal risk adjustment program under 42 U.S.C. § 18063 or access to other carrier-specific data if and where necessary and (ii) submit to the Commission an attestation that the carrier has complied with the dedicated data environments, data requirements, establishment and usage of masked enrollee identification numbers, and data submission deadlines.

2. An eligible carrier shall maintain documents and records sufficient to substantiate the requests for reinsurance payments made pursuant to this section for at least five years. An eligible 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. The Commission may audit an eligible carrier to assess the carrier's compliance with this section. The eligible carrier shall ensure that its contractors, subcontractors, and agents cooperate with any audit under this section.

D. The Commission shall calculate each reinsurance payment based on an eligible carrier's incurred claims costs for a covered person's covered benefits in the applicable benefit year net of transfers received for the same enrolled individual under the federal risk adjustment program. If the net claims costs for a covered person's covered benefits in the applicable benefit year do not exceed the attachment point for the applicable benefit year, the carrier shall not be eligible for a reinsurance payment. If the claims costs exceed the attachment point for the applicable benefit year, the Commission shall calculate the reinsurance payment as the product of the coinsurance rate and the eligible carrier's claims costs up to the reinsurance cap. A carrier shall be ineligible for reinsurance payments for claims costs for a covered person's covered benefits in the applicable benefit year that exceed the reinsurance cap. The Commission shall ensure that reinsurance payments made to eligible carriers do not exceed the total amount paid by the eligible carrier for any eligible claim. An eligible carrier may request that the Commission reconsider a decision on the carrier's request for reinsurance payments within 21 days after notice of the Commission's decision.

E. The Commission shall require each eligible carrier that participates in the Program to file with the Commission, by a date and in a form and manner specified by the Commission by rule, the care management protocols the eligible carrier will use to manage claims within the payment parameters.

§ 38.2-6603. Accounting; reports.

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 carriers;

3. Reinsurance payments made to eligible carriers; and

4. Administrative and operational expenses incurred for the Program.

B. By November 1 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 benefit year:

1. Amounts deposited into the Fund;

2. Requests for reinsurance payments received by eligible carriers;

3. Reinsurance payments made to eligible carriers;

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

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

§ 38.2-6604. Commonwealth Health Reinsurance Program 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 § 38.2-6607, the special fees paid by carriers pursuant to § 38.2-6605, 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 the "Commonwealth Health Reinsurance Program Special Fund State Corporation Commission." 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 and (ii) the establishment, operation, and administration of the Program in carrying out the purposes authorized under this chapter. 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. The Commission shall not pay any funds beyond the moneys in the Fund for the establishment, administration, or operation of the Program.

C. The provision of reinsurance payments shall not constitute an entitlement derived from the Commonwealth or a claim on any other money of the Commonwealth.

D. The Commission shall have no responsibility to make reinsurance payments that would be payable out of federal pass-through funding if such federal pass-through funding is insufficient to fully make such payments.

§ 38.2-6605. Annual assessment.

A. The Commission shall impose an annual assessment on entities authorized to issue individual and group health insurance coverage, including grandfathered plans and excluding plans offered in the small group market as defined in § 38.2-3431, in the Commonwealth. The assessment shall be one percent of a carrier's net written premiums for the preceding plan year.

B. Beginning on May 1, 2023, and no later than May 1 of each year thereafter, a carrier shall (i) pay the assessment and (ii) submit the carrier's calculation of net written premiums to the Commission, in the form and manner prescribed by the Commission.

C. The Commission shall calculate the assessment without regard to (i) the threshold limits established in § 9010(b)(2)(A) of the Affordable Care Act or (ii) the partial exclusion of net written premiums provided for in § 9010(b)(2)(B) of the Affordable Care Act.

D. In the event there is a surplus in the Fund, the Commission may utilize any excess funds for the purpose of increasing affordability in the individual market to reduce costs for consumers in accordance with the surplus.

E. The provisions of this section shall not apply to coverages issued pursuant to Title XVIII of the Social Security Act, 42 U.S.C. § 1395 et seq. (Medicare), Title XIX of the Social Security Act, 42 U.S.C. § 1396 et seq. (Medicaid) or Title XXI of the Social Security Act, 42 U.S.C. § 1397aa et seq. (CHIP), 5 U.S.C. § 8901 et seq. (federal employees), or 10 U.S.C. § 1071 et seq. (TRICARE).

§ 38.2-6606. Confidentiality of data.

Data and information that an eligible carrier considers confidential proprietary information that is provided to the Commission pursuant to the provisions of this chapter shall be excluded from, and the Commission shall not be subject to, subpoena or public inspection with respect to such information.

§ 38.2-6607. State Innovation Waiver request.

A. The Commission shall apply to the appropriate federal agencies 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 chapter, to maximize federal pass-through funding for the reinsurance program, and to waive any applicable provisions of the Affordable Care Act. An application for a State Innovation Waiver or for federal funds shall clearly state that operation of the Program is contingent on approval of the waiver or funding request. The Commission shall include in the application a request for pass-through of federal funding in accordance with § 1332(a)(3) of 42 U.S.C § 18052 to allow the Commonwealth to obtain and use, for purposes of helping finance the Program, any federal funds that would, absent the waiver, be used to pay advance payment tax credits and cost-sharing reductions authorized under the federal act.

B. The Commission shall submit the waiver application to the appropriate federal agencies by January 1, 2022. The Commission shall make a draft application available for public review and comment by October 1, 2021. The Commission may amend the waiver application as necessary to carry out the provisions of this chapter. The Commission shall promptly notify the Chairmen 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.

2. That the provisions of this act, other than § 38.2-6607 of the Code of Virginia, as created by this act, shall become effective 30 days following the date the State Corporation Commission (the Commission) notifies the Governor and the Chairmen 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 Commission pursuant to § 38.2-6607 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 Division), the Department of Taxation, health plans, agents and brokers, navigators, other consumer assisters, consumer advocates, physicians,

hospitals, 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.

4. That after the second full year of operation of the Commonwealth Health Reinsurance Program (the Program), as established by this act, the State Corporation Commission (the Commission) shall complete a study that evaluates (i) the effects of the Program on access to affordable, high-value health insurance for consumers who are eligible for premium tax credit subsidies and cost-sharing reductions and (ii) health plan affordability, including cost sharing and premiums. The Commission shall issue a report of the study within 120 days after the end of the second full year of operation of the Program, post the report on the Division's website, and submit the report to the Governor, the Chairmen of the House Committees on Labor and Commerce and Appropriations and the Senate Committees on Commerce and Labor and Finance and Appropriations, for publication as a report document as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents and reports.