CHAPTER 293

An Act to amend and reenact § 38.2-6602 of the Code of Virginia, relating to the Commonwealth Health Reinsurance Program; payment parameters.

[H 591]

Approved April 2, 2024

Be it enacted by the General Assembly of Virginia:

1. That § 38.2-6602 of the Code of Virginia is amended and reenacted as follows:

§ 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 § 38.2-6606. If the State Innovation Waiver and federal funding request submitted by the Commission pursuant to § 38.2-6606 are approved, the Commission shall implement and operate the Program in accordance with this section.

B. The Commission or its designee 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. Unless an eligible carrier is notified otherwise by the Commission, on a quarterly basis during the applicable benefit year, each eligible carrier shall report to the Commission its claims costs that exceed the attachment point for 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 Commission shall disburse all applicable reinsurance payments to an eligible carrier.

2. For the 2023 benefit year and each benefit year thereafter, the Commission 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 *(i) set such payment parameters at levels designed to achieve the premium reduction target established in the general appropriation act or, if such target is not established in the general appropriation act, the premium reduction target of the benefit year prior to the applicable benefit year and (ii)* consider the following factors: ~~(i)~~ *(a)* stabilized or reduced premium rates in the individual market, ~~(ii)~~ *(b)* increased participation in the individual market, ~~(iii)~~ *(c)* improved access to health care services and their providers for enrolled individuals, ~~(iv)~~ *(d)* mitigation of the impact high-risk individuals have on premium rates in the individual market, ~~(v)~~ *(e)* the availability of any federal funding available for the Program, and ~~(vi)~~ *(f)* the total amount available to fund the Program.

3. If the Commission determines that all reinsurance payments for a covered person's covered benefits 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 or its designee 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. If the 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.