HB0801/826488/1

BY: Health and Government Operations Committee

AMENDMENTS TO HOUSE BILL 801
(First Reading File Bill)

AMENDMENT NO. 1

On page 1, in line 2, after "Insurance -" insert "Required"; in line 14, after "market;" insert "clarifying the circumstances in which a grace period provision applies under a qualified health plan; requiring a student health plan to comply with the requirements of certain federal regulations, as interpreted and implemented by the federal Centers for Medicare and Medicaid Services; defining a certain term;"; in line 15, after the second "and" insert "required"; in line 18, strike "and"; and in line 19, after "15-1208.2(d)" insert ", 15-1315, and 15-1318".

AMENDMENT NO. 2

On page 8, in lines 3, 5, 8, 18, 21, 24, 27, and 31, in each instance, strike "**APPLICATION**" and substitute "**PLAN SELECTION**".

On page 9, in line 3, strike "**APPLICATION**" and substitute "**PLAN SELECTION**".

AMENDMENT NO. 3

On page 11, after line 14, insert:

"15–1315.

(a) (1) In this section the following words have the meanings indicated.

(2) "Individual Exchange" has the meaning stated in § 31–101 of this article.

(3) "Qualified health plan" has the meaning stated in § 31–101 of this article.

(Over)

(4) "Qualified individual" has the meaning stated in § 31–101 of this article.

(b) This section applies to a qualified health plan that is issued on or after January 1, 2014, by a carrier through the Individual Exchange.

(c) A qualified health plan subject to this section shall include a grace period provision applicable to a qualified individual who:

(1) is receiving advance payments of federal premium tax credits; and

(2) **[**has paid at least 1 full month's premium during the benefit year**]** **FAILS TO PAY PREMIUMS TIMELY**.

(d) The grace period provision shall:

(1) provide a grace period of 3 consecutive months **AFTER THE INITIAL PREMIUM PAYMENT TO BEGIN COVERAGE HAS BEEN PAID;**

(2) APPLY TO QUALIFIED HEALTH PLANS RENEWED IN ACCORDANCE WITH § 15-1309 OF THIS SUBTITLE WITHOUT THE QUALIFIED INDIVIDUAL HAVING TO PAY THE FIRST MONTH'S PREMIUM FOLLOWING RENEWAL; and

[(2)**] (3)** be in addition to any other grace period provision required by any other applicable State law.

(e) During the grace period, a carrier that issues a qualified health plan subject to this section:

(1) shall pay all appropriate claims for services rendered to the qualified individual during the first month of the grace period;

(2) may pend claims for services rendered to the qualified individual in the second and third months of the grace period;

(3) shall notify the federal Department of Health and Human Services that the qualified individual is in the grace period; and

(4) shall notify providers of the possibility that claims may be denied when a qualified individual is in the second and third months of the grace period.

15–1318.

(a) (1) In this section the following words have the meanings indicated.

(2) "Institution of higher education" has the meaning stated in the federal Higher Education Act of 1965.

(3) "Student administrative health fee" means a fee charged by an institution of higher education on a periodic basis to students of the institution of higher education to offset the cost of providing health care through health clinics regardless of whether the students utilize the health clinics or enroll in student health plan coverage.

(4) "Student health plan" means an individual health benefit plan that is provided to students enrolled in an institution of higher education and their dependents under a written agreement that:

(i) is between the institution of higher education and a carrier;

(ii) does not make coverage under the health benefit plan available other than in connection with enrollment as a student or as a dependent of a student in the institution of higher education; and

(iii) does not condition eligibility for the health benefit plan on any health status–related factor relating to a student or a dependent of a student.

(b) A carrier that offers student health plans is not required to:

(1) accept individuals who are not:

(i) students; or

(ii) dependents of students covered under the student health plan;

(2) establish open enrollment periods;

(3) establish effective dates that are based on a calendar year;

(4) offer health benefit plan contracts that are on a calendar year basis; or

(5) renew, or continue in force, coverage for individuals who are no longer students or dependents of students.

(c) A student health plan is not subject to the requirement of a single risk pool under § 1312(c) of the Affordable Care Act.

(D) A STUDENT HEALTH PLAN SHALL COMPLY WITH THE REQUIREMENTS OF 45 C.F.R. § 147.145, AS INTERPRETED AND IMPLEMENTED BY THE FEDERAL CENTERS FOR MEDICARE AND MEDICAID SERVICES.

[(d)**] (E)** A student administrative health fee is not considered a cost–sharing requirement with respect to specified recommended preventive services.".