MARYLAND HEALTH BENEFIT EXCHANGE

Authorized Producer Manual

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CHAPTER 1 – Manual Purpose

The Maryland Health Benefit Exchange Act of 2012 enables the Maryland Health Benefit Exchange (MHBE) to adopt policies, procedures, and regulations to meet federal and state requirements. This manual contains information on the policies, procedures, and regulations that have been adopted by the Maryland Health Benefit Exchange (MHBE) Board of Trustees. The purpose of this manual is to provide producers with the adopted policies, procedures, and regulations that are relevant to them.[1]

[1] Maryland Health Benefit Exchange (MHBE) refers to the public corporation and independent unit of state government.

CHAPTER 2 – About MHBE

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) was signed into law by President Barack Obama. The law provides for the creation of health insurance exchanges for all states. A health insurance exchange is a marketplace to help individuals, families and small businesses shop for coverage through easy comparison of available plan options based on price, benefits and services, and quality.

2.1 Maryland's Model: A State-Based Marketplace

The ACA provides each state the flexibility to determine the design and operating model that will work best for its citizens. An exchange may be operated by the state government, the federal government, or through services coordinated in a state-federal government partnership.

In a letter dated October 9, 2012, to U.S. Secretary of Health and Human Services Kathleen Sebelius, Governor Martin O'Malley formally declared the State of Maryland's intention to establish a state-based health insurance marketplace (SBM). In December 2012, the State of Maryland received conditional approval to operate the Maryland Health Connection, Maryland's state-based marketplace.

As a state-based exchange, Maryland is responsible for the development and operation of all core functions including:

- Consumer support for coverage decisions
- Eligibility determinations for individuals
- Enrollment in qualified plans
- Approval of participating carriers
- Certification of plans
- Operation of a Small Business Health Options Program (SHOP)
- Consumer Assistance programs

CHAPTER 3 – The MHBE-Producer Partnership

3.1 Overview

Insurance producers play an important role in ensuring Marylanders have access to affordable health care insurance options. As trained and licensed professionals, insurance producers are the only consumer assistance workers who are qualified to advise their consumers on enrolling in a plan that is best suited to their needs. The Maryland Health Benefit Exchange understands the importance of insurance producers to the general public, and as a result, we have created the Producer Authorization Program.

3.2 The Producer Authorization Program

The MHBE has designed a three-step process for licensed health insurance producers seeking their initial authorization.

- Step 1 – Submit the Producer Authorization Application with required documentation
- Step 2 – Complete the MHBE Training
- Step 3 – Receive Notification of Authorization from MHBE

Upon completion of these three steps, licensed producers will be authorized to sell plans offered on Maryland Health Connection. Only producers who have received authorization can sell Maryland Health Connection plans.

Producer authorization expires two years after the date it is issued. MHBE will send out a renewal notice to authorized producers no later than 60 days prior to the expiration of their two year authorization period. Authorized producers will need to respond to that renewal notice at that time if they would like to renew their authorization.

Out-of-state and/or Federal Exchange authorization will not be accepted as a replacement for Maryland authorization.

A licensed health insurance producer can apply as long as they meet the following criteria:

- Holds a current license issued by the Maryland Insurance Commissioner that qualifies the Producer to sell health benefits in Maryland
- Maintains a sufficient level of Errors and Omissions (E&O) coverage
- Is not excluded from participation in Federal health programs
- Is not barred from State contracts
- Agrees to present all plans from all participating carriers and disclose appointment status to consumers
- Agrees to adhere to privacy and security standards established by the MHBE
- Agrees to work cooperatively with Connector Entities/Navigators, as applicable
- Agrees to immediately report concerns or complaints from employers, employees or individual consumers to the appropriate agency in a timely manner
- Agrees to comply with all training requirements

Both resident and non-resident producers are eligible to apply.

3.2.1 Step 1 – Producer Authorization Application

The Producer Authorization Application can be found at https://mhbe.force.com/training/CustomCommunityLogin.

The Producer Authorization Application will provide valuable information about the producer to MHBE. Once a producer is authorized, the information provided on the application will be displayed on Maryland Health Connection, enabling consumers to reach out to the producer for assistance. Additionally, the information provided will also be sent to the insurance carrier(s) for compensation purposes each time a producer completes an enrollment.

Once a producer's application is reviewed, the Producer Operations Team will send a detailed reply email with the requirements to become authorized. Producers must submit or complete the following to comply with Initial authorization requirements:

- Copy of E&O Certificate
- Copy of MD Insurance License
- Signed Non-Exchange Entity Agreement
- Signed Attestation – Not required for captive producers
- Signed Captive Producer Attestation – Only required for captive producers
- Symantec Credential ID – Not required for producers requesting authorization for the SHOP Exchange only
- Required training
- Proof of identity – Only required if it is unclear whether the producer is excluded from participation in Federal health programs or if it is unclear whether the producer is barred from State contracts

The application process must be completed within 45 days of the application being submitted; this includes sending in the required documentation and completing the required training. After 45 days, if the application process has not been completed, the application will be discarded.

3.2.2 Step 2 – MHBE Training

A producer must complete the Producer Authorization training in order to become an Authorized Producer. Only training offered by MHBE will be accepted for authorization. Training for the Federal Exchange or other State Exchanges cannot be substituted in lieu of the Maryland Health Benefit Exchange Producer Authorization training.

Producers will receive detailed training instructions. Depending on the producer's requested authorization status, the producer will be required to complete one or more of the following courses. While some producers may not be required to complete every course, they may choose to do so since the courses contain valuable information. All of the modules listed below will be available in an online, self-directed format for producers to complete at their own pace.

Module: Producer (IND/SHOP) Pre-Authorization Training 18-19 –New Staff

Module: Simplifying SHOP: Broker Tool & Marketing Techniques

Module: 2018 SHOP Overview

Module: 2018 Annual Training Returning Producer Individual & SHOP

Module: Post 2018 Annual Training Compliance - Producers

3.2.3 Step 3 – Notification of Authorization

After an application has been received, reviewed, and approved, following the completion of all of the authorization requirements, MHBE will send out notification that the Producer has been authorized to sell plans on Maryland Health Connection. As part of this email notification, producers will receive their MHBE Authorization Letter and the Authorized Producer Seals. If a producer is authorized for the individual marketplace, the producer will also receive a separate auto-generated email with their login credentials for their Producer Portal on Maryland Health Connection.

3.3 Application Updates

Authorized Producers should notify MHBE of any changes to the information provided on their application within 30 days of such a change. These changes include updates to a producer's name, business address, telephone number, email address, company of employment, Symantec ID, and/or a producer's captive status. The change of information should be completed by logging into Salesforce LMS at https://mhbe.force.com/training/CustomCommunityLogin and updating the existing, approved application.

3.4 Mid-year Documentation Updates

During the year, if an Authorized Producer's license issued by the Maryland Insurance Commissioner is about to expire, or if the producer's Errors & Omissions (E&O) insurance is about to expire, MHBE Producer Operations will contact the producer to request an updated Maryland Insurance License and/or an updated E & O Certificate. If this information is not provided in the time period requested, this could result in the suspension or revocation of a producer's authorization.

3.5 Authorization Renewal

Producer authorization expires two years after the date it is issued. MHBE will send out a renewal notice to authorized producers no later than 60 days prior to the expiration of their authorization. If a producer wishes to renew their authorization, the producer will need to reply to the renewal notice, indicating their intent. If renewing, the producer will also need to submit an updated Attestation, an updated Non-Exchange Entity Agreement, and their current contact information. Once the producer has submitted the required renewal information, MHBE Producer Operations will confirm the producer's eligibility to renew and issue the producer a new MHBE Authorization Letter with a new two-year term.

3.6 Required Annual Retraining

Authorized Producers will be required to meet annual retraining requirements prior to Open Enrollment each year. MHBE Producer Operations will send Authorized Producers an email when retraining requirements need to be met, including detailed instructions on how to complete the required training. Depending on the producer's current authorization status, the producer will be required to complete one or more of the following courses. All the modules listed below will be available in an online, self-directed format for producers to complete at their own pace.

Module: 2018 Annual Training Returning Producer Individual & SHOP

3.7 Suspension or Revocation

The MHBE may suspend or revoke a producer's authorization as set forth under Insurance Article, §31-113(m)(3), Annotated Code of Maryland.

3.8 Authorization Reinstatement

If a producer's authorization is suspended, the producer can contact MHBE Producer Operations to ascertain what requirements need to be met for reinstatement, as long as the producer is still in the two-year authorization period listed on their Authorization Letter. The producer can contact MHBE Producer Operations at mhbe.producers@maryland.gov .

If a producer is suspended and their two-year authorization period lapses, the producer will need to complete a new Authorization Application in order to be reinstated.

3.9 Captive Producers

The Maryland Insurance Administration, on July 15, 2013, issued Bulletin 13-22 regarding Fair Marketing Standards for Captive Producers. The Bulletin states:

The Maryland Health Progress Act of 2013 (Ch. 159, 2013 Acts), among other things, establishes standards relating to captive producers and § 31-113(p)(3)(i)(1) of the Insurance Article directs the Maryland Health Benefit Exchange and the Maryland Insurance Administration to jointly develop fair marketing standards by which captive producers authorized to sell plans on the Individual Exchange must disclose specific information to individuals seeking to purchase plans through the Individual Exchange.

A Captive Producer is defined in § 31-101(c-1) as an insurance producer who:

1. Is licensed in the state and authorized by the Commissioner to sell, solicit, or negotiate health insurance;
2. Receives an authorization and meets the other requirements set forth in § 31–113(n)(2) of this title;
3. Has a current and exclusive appointment with a single carrier; and
4. Receives compensation as a captive producer only from that carrier.

Producers who are retained under contract to exclusively sell new plans for a single carrier, but who have additional appointments solely for the collection of residual commissions also are considered captive producers.

Captive Producers:

- May transition the carrier's existing **individual** enrollees into Maryland Health Connection qualified plans, and may provide enrollment assistance to individuals who contact the carrier;
- Must act in best interests of the consumer;
- Must disclose their employment with the carrier;
- Are subject to the same restrictions as navigators; and
- Are subject to the same licensing and MHBE authorization requirements as authorized producers;
- Carriers must:
    - document and retain records of such disclosures for three years;

- provide disclosure records and updated lists of captive producers to Exchange

Non-compliance with any of the above requirements is grounds for sanctions for both the captive producer and the carrier.

Programs must be administered in non-discriminatory manner without adverse selection impact.

The Maryland Health Benefit Exchange and the Maryland Insurance Administration have jointly developed the following fair marketing standards in accordance with the charge laid out in § 31-113(p)(3)(i)(1) of the Insurance Article, Annotated Code of Maryland. Captive producers holding an insurance producer authorization for the Individual Exchange shall make the following disclosure to all applicants:

"NOTICE OF AVAILABILITY OF HEALTH COVERAGE THROUGH MARYLAND HEALTH CONNECTION

As a captive producer appointed exclusively by _____ (Carrier),

I am legally obligated to disclose that:

I am only able to provide information about and sell qualified plans offered by _____ (Carrier). Maryland Health Connection offers a variety of qualified plans sold by other carriers that may meet your needs. Maryland Health Connection also performs eligibility determinations for Medicaid. At any time, upon your request, I am required to refer you to an independent authorized insurance agent, the appropriate consumer assistance organization in your region, or the Maryland Health Connection call center; and provide written information about Maryland Health Connection, the consumer assistance program, and the customer service center."

This disclosure statement shall:

1. Be provided to an applicant before any information or assistance is given with respect to qualified plans offered for sale through the Individual Exchange;
2. Be made on a separate document in at least 12 point font if issued in writing; and
3. Be recorded and stored in a format which can later be recovered, if issued in electronic or telephonic format.

Additionally, a captive producer and the producer's associated carrier shall retain documentation of the disclosure for three years along with the acknowledgements required by Insurance Article, § 31-113(p)(4)(iii), Annotated Code of Maryland.

3.10 Producer Compensation

As indicated in the Maryland Health Benefit Exchange Act of 2012, an insurance producer may not be compensated by the individual exchange for the sale of a qualified health plan or qualified dental plan offered in the individual exchange; carriers will continue to be responsible for compensation of producers that sell plans on Maryland Health Connection. Carriers will continue to develop their own models of compensation for producers. Carriers are expected to develop equivalent compensation and incentives for sales inside and outside of Maryland Health Connection.

Additionally, carriers are required to collect and maintain Producer compensation data including agreements, policies, procedures, programs and other information regarding Producer compensation both within Maryland Health Connection and in the individual and small group insurance markets outside

of Maryland Health Connection. Carriers must provide this information to the Maryland Insurance Administration upon request.

3.10.1 MHBE Carrier Contacts and Contracting Requirements

MHBE has authorized the following insurance carriers to offer plans on Maryland Health Connection. The authorized insurance companies include:

- Aetna (SHOP only)
- CareFirst: CareFirst of Maryland Inc., CareFirst BlueChoice Inc., Group Hospitalization and Medical Services Inc.
- Delta Dental: Delta Dental of Pennsylvania, Alpha Dental Programs, Inc., Dentegra Insurance Company
- DentaQuest Mid-Atlantic, Inc.
- Dominion Dental Services Inc. (Individual Exchange only)
- Kaiser Foundation Health Plan of the Mid-Atlantic
- United Healthcare (SHOP only)

Below are the points of contact for becoming appointed with each carrier, along with any contracting requirements that have been provided to MHBE by the carrier.

Aetna (*Aetna only participates in the SHOP Exchange.)

Point of Contact:

David Brock, Senior Manager
(800) 727-9951
dlbrock@aetna.com

CareFirst

Point of Contact:

Alexis Hippe, Sr. Regulatory Project Manager
(410) 998-5700
alexis.hippe@carefirst.com

United Health Care (*UHC only participates in the SHOP Exchange)

Point of Contact:

Katherine Kenny, SB VP of Account Management
(443) 896-9136
kathy_kenny@uhc.com

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.

Point of Contact:

Sheebani Patel, Sr. Manager, Public Exchanges
(301) 816-7233
sheebani.S.Patel@kp.org

Contracting Requirements (Required even if you are contracted with CareFirst off-Exchange already):

- Request a contracting agreement via BCC@CareFirst.com
- Provide CareFirst with a copy of your MHBE Authorization Letter
- Select a General Agent from via https://broker.carefirst.com/carefirst-resources/broker-pdf/consumer-direct-contractor-list.pdf
- Complete a W-9 via https://broker.carefirst.com/carefirst-resources/broker-pdf/W9_Form.pdf - only required if the producer receives authorization to not select a General Agent
- Provide CareFirst with your Errors & Omissions Certificate and your MD Insurance License

These documents should be submitted to BCC@CareFirst.com for processing.

Alpha Dental and Delta Dental

Point of Contact:

- Producerservices@delta.org

Contracting Requirements:

- https://www.deltadentalins.com/brokers/

Dentegra

Point of Contact:

- producerservices@dentegra.com

Contracting Requirements: https://www.dentegra.com/for-brokers

Dominion Dental

Point of Contact:

Bryan Cabrera
Commissions Specialist
(703) 518-5000
bcabrera@dominiondental.com

Contracting Requirements:

- To request a producer kit, please call Dominion Dental's Group Service Center at 877-559-9624 or send an email to gsc@DominionDental.com

Kaiser Permanente

Point of Contact:

Broker Shared Service Center
(844) 268-2943

BrokerSupport-MAS@kp.org

Contracting Requirements:

- Complete a Broker Information Sheet via https://account.kp.org/static/bcssp/pdfs/broker/mid/ever/KP_MAS_Broker_Information_Sheet.doc
- Complete a W-9 Form via https://account.kp.org/static/bcssp/pdfs/shared/mid/ever/KP_MID_Fillable_W9_Form.pdf
- Submit proof of your E&O Insurance Coverage
- Complete a Broker Agreement via https://account.kp.org/static/bcssp/pdfs/broker/mid/ever/KP_MAS_Broker_Agreement_Contract.pdf
- Submit your Direct Deposit Form – if requested by Kaiser Permanente

Mail, email, or fax copies of these documents to:

- Kaiser Permanente
  Broker Shared Service Center
  Email: BrokerSupport-MAS@kp.org
  3100 Thornton Avenue, 3rd Floor
  Burbank, CA 91504
  Phone: (844)268-2943
  Fax: (818)557-3983

Kaiser Permanente will apply for all broker appointments on behalf of the broker and will pay all fees associated with becoming appointed with Kaiser Permanente. Brokers will receive notification about the status of their appointment.

UnitedHealthcare

UnitedHealthcare does not pay commission nor offer appointments.

3.11 Producer of Record Policy

Once a producer is authorized, they will receive log-in credentials for the Producer Portal on Maryland Health Connection. The Producer Portal allows the producer to connect with consumers through a "tango" process, and track the consumers they assist and enroll through the Exchange. The tango process must be completed so that the producer's name and NPN are submitted to the carrier with the consumer's enrollment as the Producer of Record. If the tango process is not completed before enrollment, the tango can be completed at a later time, but commission is paid from the date of tango, not the original date of enrollment, so best practice is to tango at the beginning of the producer-consumer relationship.

Please note, producers that are only participating in the SHOP Exchange will not receive log-in credentials for the Producer Portal. Additionally, all Producer of Record updates for SHOP business will take place with the insurance carriers directly. See Section 6.2 for additional information regarding the SHOP Exchange.

3.11.1 Becoming a Producer of Record When Completing an Enrollment

If the producer is completing an application with a consumer, the below procedure outlines how to become the Producer of Record before completing the enrollment:

Step 1: The consumer should log into their consumer account at www.marylandhealthconnection.gov and select "Find Assistance" on their home page. The consumer should then search for and select the producer they wish to designate as their Producer of Record.

Step 2: The producer must then log into their Producer Portal and select "accept Client Partnership Request." Once the producer "accepts," the subsequent new enrollment file will go to the carrier with the producer as the Producer of Record.

3.11.2 Becoming a Producer of Record When the Enrollment Has Already Been Completed

Once a consumer has enrolled in a plan through Maryland Health Connection, they may add or change their Producer of Record at any time by completing the "tango" process, outlined above, with their designated producer.

3.11.3 Producer of Record Special Circumstances

Maryland Health Connection reserves the right to make a Producer of Record change under special circumstances such as:

- Producer death or disability
- Producer retirement
- Suspension or revocation of the Producer's license by the Maryland Insurance Commissioner

3.11.4 Producer of Record Issues

From time to time, producers find that they are not receiving a commission for one or more of their enrollments. When this situation occurs, producers should address the following question:

- Is the enrollment in question on the Book of Business?

MHBE Producer Operations sends producers their Book of Business via email approximately once every 1 - 2 months.

Producers should verify whether the enrollment in question is listed on their Book of Business. Producers should not use their consumer list in their Producer Portal to verify that they are listed as the Producer of Record for a consumer.

If the enrollment is not listed on the producer's Book of Business, the producer should send MHBE Producer Operations a secure email stating that the enrollment is not listed on their Book of Business. MHBE Producer Operations will investigate why the enrollment is not on the Book of Business and will advise on how to proceed.

If the enrollment is listed on the producer's Book of Business, the producer should proceed as follows:

- If the producer uses a TPA, the producer should have their TPA contact the carrier to address the commission issue.
- If the producer does not use a TPA, the producer should contact the carrier directly to address the commission issue.

The carrier will be able to advise whether there is a contracting issue, whether the consumer was terminated for non-payment, etc. In the event that the carrier says that MHBE did not send a file with the producer listed as the Broker of Record, the producer should send MHBE Producer Operations a secure email stating such. If this is the case, MHBE Producer Operations will investigate, and if necessary, arrange to have the producer updated at the carrier as the Producer of Record.

MHBE Producer Operations can be contacted via email at mhbe.producers@maryland.gov.

Please note, MHBE does not pay commissions. Commission disputes should be addressed with the carrier. MHBE can only assist in ensuring that a producer is listed as the Producer of Record at the carrier.

Please note also, if the producer is manually updated as the Producer of Record by MHBE Producer Operations, it may take some time before the enrollment shows up on the producer's Book of Business.

Producer of Record Issues for SHOP business should be directed toward the insurance carriers. Producers may contact the SHOP team at mhbe.shop@maryland.gov for escalated SHOP Producer Issues.

3.12 Producer Marketing Guidelines

- Insurance Producers authorized by the Maryland Health Benefit Exchange to sell plans through Maryland Health Connection will receive a "seal" to display on marketing materials, such as: brochures, business cards, advertisements, pamphlets, etc.

- The Maryland Health Connection logo may not be used or displayed on marketing materials developed by Authorized Producers.

- Only the seal "Authorized Insurance Broker/Maryland Health Connection" may be used on marketing and outreach materials.

- Any presentations and materials produced by the MHBE and Maryland Health Connection must not be altered or reproduced without the consent of the Maryland Health Benefit Exchange.

- Authorized Producers may attend community outreach events organized by Maryland Health Connection with prior approval from the marketing department. Authorized Producers may distribute business cards at these events. Pamphlets or other marketing materials may not be distributed unless authorization has been obtained through the Marketing Department at the Maryland Health Benefit Exchange at least two weeks prior to the event.

- Authorized Producers may host community outreach events. All events must include information about all insurance carriers and plans available through Maryland Health Connection in an unbiased manner.

- Community outreach events are also organized by consumer assistance organizations authorized by MHBE, that employ or engage personnel to determine eligibility based on a consumer's application and provide other consumer assistance functions. Producers cannot attend community outreach events organized by these organizations unless they receive authorization from the organization prior to the event. Contact information can be found here:
    - https://www.marylandhealthconnection.gov/get-help-enrolling/

3.12.1 Authorized Insurance Broker Seal

Producers who have successfully completed training and all other authorization requirements will be sent the below seals to notify consumers they are authorized to sell plans offered on Maryland Health Connection.

3.13 Producer Support

MHBE is committed to providing the support necessary to ensure the success of Authorized Producers.

3.13.1 The Producer Operations Team

MHBE has established a Producer Operations team to provide support to Maryland's Producers. The Producer Operations team can help with:

- The MHBE Producer Authorization Program
- Maryland Health Connection policies and procedures
- Producer system access issues (passwords, etc.)

The Producer Operations team cannot help with:

- Non-Maryland Health Connection market issues
- Producer relationships with exchanges in other states
- General, non-exchange-related aspects of health reform under the ACA

To reach the Producer Operations team, send an e-mail to mhbe.producers@maryland.gov .

3.13.2 The Producer Support Hotline

The MHBE Call Center has a designated team of Producer Support Representatives who can help Authorized Producers with their consumer enrollment issues. The Producer Support Hotline can help with:

- Consumer enrollment issues
- Consumer system access issues (passwords, etc.)
- Producer system access issues (passwords, etc.)

The Producer Support Hotline cannot help with:

- Producer Authorization issues
- Producer training issues

To reach the Producer Support Hotline, call 844-224-6761.

3.13.3 Escalated Cases Support

From time to time, producers may find a consumer has a problem with their on-Exchange application or enrollment. When situations like this occur, producers can escalate these cases via one of two channels:

- By calling the Producer Support Hotline at 844-224-6761
- By sending an email to mhbeproducer.escalatedcases@maryland.gov

If cases are emailed to mhbeproducer.escalatedcases@maryland.gov , the producer must include the following information in the email:

- The Application ID associated with the consumer's issue – Put this in the subject line of the email
- The consumer's Person ID (if available)
- The nature of the problem
- The requested effective date – the consumer will be offered and must choose one of the following effective dates:
    - The effective date of the initial enrollment
    - The next prospective effective date
- The name and NPN of the producer who should be credited with the enrollment

Cases emailed to mhbeproducer.escalatedcases@maryland.gov should not be encrypted **and must not include any PII.**

Producers should also make consumers aware that once an effective date is requested the date cannot be changed and, if a retroactive effective date is requested, the consumer will be held liable for any retroactive premiums.

3.13.4 The Small Business Health Options Program (SHOP) Team

MHBE has established a SHOP team to provide support to Maryland's Producers. The SHOP team can help with:

- SHOP policies and procedures

- SHOP employer enrollment issues

The SHOP team cannot help with:

- Individual Marketplace policies and procedures
- Individual Marketplace enrollment issues

To reach the SHOP team, send an e-mail to mhbe.shop@maryland.gov .

3.13.5 MHBE Training Support

MHBE's Training Support Team operates an email support box to help producers with their training-related issues. The MHBE Training Support Team can help with:

- Issues with starting or completing training

The MHBE Training Support Team cannot help with:

- Producer Authorization issues
- Consumer issues

To reach the MHBE Training Support team, write to mhc.trainingsupport@maryland.gov .

CHAPTER 4 – Carriers and Plans

4.1 Authorized Carriers

For the 2018 Plan Year, MHBE has authorized the following insurance carriers to offer plans on Maryland Health Connection. The authorized insurance companies include:

- Aetna (SHOP only)
- CareFirst: CareFirst of Maryland Inc., CareFirst BlueChoice Inc., Group Hospitalization and Medical Services Inc.
- Delta Dental: Delta Dental of Pennsylvania, Alpha Dental Programs, Inc., Dentegra Insurance Company
- DentaQuest Mid-Atlantic, Inc.
- Dominion Dental Services Inc.
- Kaiser Foundation Health Plan of the Mid-Atlantic
- United Healthcare (SHOP only)

Summaries of Benefits and Coverage (SBCs) for each plan offered on Maryland Health Connection can be found on the plan shopping page after completing the anonymous browsing form:

- https://secure.marylandhealthconnection.gov/AHCT/FamilyInformation.action

4.2 Benefit Design Requirements

Maryland Health Connection offers a variety of HMO and PPO medical plan designs. Stand-alone dental plans, including DHMO and DPPO designs, are also available. Qualified plans sold to consumers via Maryland Health Connection must meet all applicable federal and state laws in order to be certified. The Maryland Insurance Administration (MIA) performs a review of forms and rates to ensure compliance with the following areas required in the ACA:

4.2.1 Qualified Health Plans (QHPs)

4.2.1.1 Essential Health Benefits (EHB)

The ACA requires that, as of January 1, 2014, all non-grandfathered small group and individual health benefit plans sold inside and outside of health benefit exchanges must cover a core set of "essential health benefits" as defined by the U.S. Department of Health and Human Services (HHS). These EHBs must include items and services within the 10 core benefit categories below:

- Ambulatory patient services (outpatient services)
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services ,including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices (those that help patients acquire, maintain, or improve skills necessary for daily functioning)
- Laboratory services
- Preventive and wellness services and chronic disease management

- Pediatric services, including oral and vision care

The EHBs are defined by the benchmark plan, reflecting both the scope of services and any limits offered by a typical employer plan in that state. The benchmark plan sets the minimum scope of services that must be included in every plan design.

The Maryland Health Benefit Exchange Act of 2012 directed the Health Care Reform Coordinating Council (HCRCC) to select Maryland's initial EHB benchmark plan.

For 2018, there are two benchmark plans: KP MD Silver 2750/20%/HSA/Dental in zip codes where KP and CF compete. BluePreferred PPO Silver $3,500 VisionPlus in zip codes where only CF has a presence.

4.2.1.2 Qualified Health Plan (QHP) Metal Tiers/Actuarial Value

The ACA requires that, as of January 1, 2014, with the exception of grandfathered plans, all small group and individual health benefit plans sold inside and outside of health benefit exchanges must meet metal tier and actuarial value (AV) requirements. This means that non-grandfathered plans offered by carriers must meet distinct levels of coverage referred to as "metal tiers"—bronze, silver, gold, or platinum:

- Bronze plan—AV of 60 percent;
- Silver plan—AV of 70 percent;
- Gold plan—AV of 80 percent;
- Platinum plan—AV of 90 percent.

The Center for Consumer Information and Insurance Oversight (CCIIO) has noted that for 2018 and future plan years, a variation of -4/+2 percentage points in AV is allowable. For example, a silver plan could have an AV range between 66 percent and 72 percent.

In addition to the four metal levels, carriers can also offer catastrophic plans. Catastrophic plans are available to individuals who:

- Meet the general eligibility requirements for a QHP (must be a Maryland resident, not incarcerated and a US citizen/national/lawfully present)
- Are up to age 30 prior to the first day of the plan or policy year
- Or if over age 30, have received a certificate of exemption because of either hardship or a lack of affordable coverage, which includes living in a zip code where only one carrier offers plans on the marketplace

Catastrophic plans are available only in the individual market and must cover essential health benefits. If a consumer enrolls in a catastrophic plan, they will not be eligible for tax credits lower premium costs or cost sharing reductions to reduce out of pocket costs.

4.2.1.3 Cost-Sharing Limitations

For 2019 coverage, the maximum out-of-pocket for a CSR Silver plan will increase for all eligible enrollees: For applicants with income between 100 and 200 percent of the poverty level, it will be $2,600 for a single individual and $5,200 for a family. For applicants with income between 200 and 250 percent of the poverty level, it will be $6,300 for a single individual and $12,600 for

a family. The unsubsidized maximum out of pocket limits will be $7,900 for an individual and $15,800 for a family.

4.2.1.4 Non-Discriminatory Benefit Design

The ACA prohibits health insurance carriers from making any coverage decisions, determining reimbursement rates, establishing incentive programs, or designing benefits in ways that discriminate against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependence, quality of life, or other health condition.

4.2.1.5 Mental Health Parity and Addiction Equity Act

The ACA requires that, as of January 1, 2014, all non-grandfathered individual and small group plans must comply with the Mental Health Parity and Addiction Equity Act.

4.2.2 Stand-Alone Dental Plans (SADPs)

4.2.2.1 Essential Health Benefits

The final rule issued by HHS on Standards Related to Essential Health Benefits, Actuarial Value and Accreditation, states that all SADPs offered on Maryland Health Connection must contain, at a minimum, the pediatric dental portion of the EHB package.

4.2.2.2 Stand-Alone Pediatric Dental Plan Tiers/Actuarial Value

The ACA requires that, as of January 1, 2014, all SADPs sold inside health benefit exchanges must meet actuarial value (AV) requirements. SADPs offered by carriers must meet distinct levels of coverage referred to as "tiers" — high or low.

Each plan in a tier must meet the specified AV requirements based on the cost-sharing features of the plan:

- "Low" plan—AV of 70 percent;
- "High" plan—AV of 85 percent.

CCIIO issued a bulletin noting that a de minimis variation of +/- 2 percentage points in AV is allowable. For example, a low plan could have an AV value with a range between 68 percent and 72 percent.

4.2.2.3 Cost-Sharing Limitations

The MHBE Board of Trustees adopted a policy that defines the out-of-pocket (OOP) maximum for SADPs.

For pediatric SADPs, the OOP maximum for one covered child is $1,000 per year. For two or more covered children, the OOP maximum is $2,000 in aggregate per year. No lifetime limits are allowable for pediatric SADPs.

For family SADPs, the adult portion of the dental plan is not considered an EHB and therefore, the requirements for OOP maximums or prohibition of lifetime limits will not apply. The OOP maximums will apply only to the pediatric portion of the SADP.

4.2.2.4 Non-Discriminatory Benefit Design

The ACA provides new market rules governing the behaviors of both dental and health insurers. Applied, they prohibit all dental insurance carriers providing pediatric dental benefits on the Exchange from making any coverage decisions, determining reimbursement rates, establishing incentive programs, or designing benefits in ways that discriminate against individuals because of their age, expected length of life, present or predicted disability, degree of medical dependence, quality of life, or other health condition.

4.3 Rating Rules

The ACA restricts the variation of premiums for health benefit plans, both inside and outside of health benefit exchanges. Premiums must be calculated using adjusted community rating and may only vary by the following rating factors:

- Age (3:1 max)
- Rating Regions
- Family Composition
- Tobacco Use (1.5:1 max) – Note, Maryland does not apply tobacco rating

The final rule from HHS regarding Health Insurance Market Rules and Rate Review (45 CFR § 147.102) specifies that rates for families must be determined by aggregating the individual rates for each family member and accounting for factors such as age and tobacco use. With respect to family members under the age of 21, the premiums for no more than the three oldest covered children must be taken into account in determining the total family premium. In the SHOP, carriers must calculate rates on a per-member basis with the same rules regarding family members under the age of 21. At this time, participating SHOP carriers are not offering composite premiums.

4.3.1 Age

The ACA establishes rate bands across three age brackets (under 21 yrs., 21 to 64 yrs., and over 64 yrs.). For each band the ACA provides specific rules for premium rate determination. For the 21 to 64 yrs. age band, carriers can use a maximum 3:1 variation of the premium rate. For the under 21 yrs. and over 64 yrs. age bracket there is one rate band each.

4.3.2 Tobacco Use

The ACA allows carriers to use a maximum 1.5:1 rate variation for consumers with no tobacco use vs. those with tobacco use. Maryland does not apply tobacco rating.

4.3.3 Rating Regions

Maryland is divided into four rating regions for both the individual and small group markets:

- Baltimore Metropolitan: Baltimore City, Baltimore County, Harford County, Howard County, Anne Arundel County
- Eastern and Southern Maryland: St. Mary's County, Charles County, Calvert County, Cecil County, Kent County, Queen Anne's County, Talbot County, Caroline County, Dorchester County, Wicomico County, Somerset County, and Worcester County
- Washington D.C. Metropolitan: Montgomery County and Prince George's County
- Western Maryland: Garrett County, Allegany County, Washington County, Carroll County and Frederick County

4.3.4 Family Composition

Under the new rules established by the ACA, each family's rate is determined by adding together the individual rates (calculated in Maryland by age and location) of the following:

- The enrollee
- The enrollee's spouse
- The enrollee's dependents over age 21
- The oldest three of the enrollee's dependents under age 21

CHAPTER 5 – Individual and Family Subsidies

5.1 Individual and Family Subsidies

For Marylanders with income from 138% to 400% of the Federal Poverty Level (FPL), tax credits are available to reduce the amount of monthly premiums for private insurance plans purchased through Maryland Health Connection. Additionally, for Marylanders with income from 100% to 250% of the FPL, cost sharing reduction plans that reduce the amount of co-pays, coinsurance and deductibles are also available.

In addition to the tax credits and cost sharing reduction tools created to increase coverage, Maryland implemented the Medicaid expansion option. Marylanders with income less than 138%* of FPL, with respect to family size, who are otherwise eligible, are eligible for enrollment in the state Medicaid program. Certain Maryland residents may not be eligible for Medicaid programs even if income is below 138% of FPL due to their immigration status.

All Marylanders are eligible to purchase a qualified health plan on Maryland Health Connection, but not all will be eligible to receive a tax credit. Similarly, Marylanders who qualify for Medicaid are still eligible to purchase a qualified health plan on the Marketplace, but will be unable to receive any tax credits to assist in paying for that plan.

*States that participate in the Medicaid expansion option must offer coverage for those making up to 133% of FPL, however a 5% disregard for income is also applied - effectively increasing eligibility up to 138% of FPL.

Family Size	2018 Poverty Guidelines - Annual							
	100%	133%	138%	150%	200%	250%	300%	400%
1	$12,140	$16,146	$16,753	$18,210	$24,280	$30,350	$36,420	$48,560
2	$16,460	$21,892	$22,715	$24,690	$32,920	$41,150	$49,380	$65,840
3	$20,780	$27,637	$28,676	$31,170	$41,560	$51,950	$62,340	$83,120
4	$25,100	$33,383	$34,638	$37,650	$50,200	$62,750	$75,300	$100,400
5	$29,420	$39,129	$40,600	$44,130	$58,840	$73,550	$88,260	$117,680
6	$33,740	$44,874	$46,561	$50,610	$67,480	$84,350	$101,220	$134,960
7	$38,060	$50,620	$52,523	$57,090	$76,120	$95,150	$114,180	$152,240
8	$42,380	$56,365	$58,484	$63,570	$84,760	$105,950	$127,140	$169,520
Add $4,320 for each person over 8								

Medicaid is also available for pregnant women below 264% FPL, Maryland Children's Health Program (MCHP) is available for children under 200% FPL, and MCHP Premium is available for children between 200% and 300% FPL. A premium of $54 or $67 is required for MCHP premium. The premium is determined by the household's FPL. If an individual has an income below 138% FPL, but if an individual does not qualify

for Medicaid due to immigration status, the individual may qualify for tax credits and cost sharing reductions.

You may be eligible for Medicaid if your annual income is up to approximately:					
If your household size is this	Adults	Children (MCHP)	Children (MCHP Premium*)		Pregnant Women
1	$16,753	$25,616	$32,050	$39,091	N/A
2	$22,715	$34,731	$43,455	$53,002	$43,455
3	$28,676	$43,846	$54,860	$66,912	$54,860
4	$34,638	$52,961	$66,264	$80,822	$66,264
5	$40,600	$62,077	$77,669	$94,733	$77,669
6	$45,561	$71,192	$89,074	$108,643	$89,074
Each person add	$5,962	$9,116	$11,405	$13,911	$11,405
You Pay	$0	$0	$54	$68	$0

Effective March 1, 2018
*Premium cost is per family/household each month.

5.1.1 Advance Premium Tax Credit

Individuals who qualify for the premium tax credit may choose how they take advantage of the tax credit. These individuals may:

- Use the maximum tax credit for which they qualify to reduce their monthly premium costs.
- Take the tax credit at the end of the year when filing federal income tax.
- Use a portion of the tax credit to reduce their monthly premium costs and defer the rest of the credit to the end of the year when filing federal income tax.

If the individual chooses to apply any portion of their tax credit to their monthly premium costs, carriers will receive payment for that portion of the premium directly from the U.S. Treasury. An individual's tax credit amount is determined based on their expected income for the coming benefit year. Individuals whose incomes change over the course of the benefit year such that their tax credit becomes too generous for their income, or they become ineligible for tax credits, should report the change in income to Maryland Health Connection. In addition, the consumer must reconcile these credits with their tax payment. For additional information on the tax credit and how it can be claimed, please review IRS's final regulation.

http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf

5.1.2 Cost-sharing Reductions

Marylanders whose income falls between 100% and 250% of FPL may qualify to choose a plan with significantly reduced cost sharing, including reductions in deductibles, copays and coinsurance. Unlike an APTC, a cost sharing reduction (CSR) is not a tax credit. A CSR simply makes a silver metal level plan more affordable for a consumer by reducing or eliminating co-pays and, lowering deductibles or coinsurance. Consumers can only take advantage of CSRs if they enroll in a silver metal level plan. Enrollment in non-silver metal level plans will result in the consumer receiving no CSRs.

There are specially designed limited and zero-cost sharing plans available for eligible members of federally recognized Native American tribes or Alaska natives. If an eligible individual has income up to 300% FPL, they are eligible for a zero cost sharing plan. If an individual has income above 300% FPL, or does not request consideration for financial assistance, they are eligible for a limited cost sharing plan.

CHAPTER 6 – Enrollment and Termination of Coverage

6.1 Individual QHP, Dental, and Medicaid Enrollment

6.1.1 Annual Open Enrollment

The Annual Open Enrollment Period is a period of time each year during which any individual eligible to enroll in a QHP through Maryland Health Connection may enroll in a plan or change coverage. The Open Enrollment Period for 2019 is Nov. 1 to Dec. 15, 2018.

There is no Open Enrollment Period for Medicaid/MCHP. Consumers can enroll in Medicaid year-round if they are eligible.

6.1.1.1 Open Enrollment Effective Dates

Consumers that enroll between Nov. 1, 2018 and Dec. 15, 2018 will have coverage beginning Jan. 1, 2019.

6.1.1.2 Annual Renewal of Coverage

One month prior to Open Enrollment, consumers who are currently enrolled through Maryland Health Connection will receive an Annual Renewal Notice. The Annual Renewal Notice will state that the consumer is either eligible or ineligible for automatic renewal. If the consumer is ineligible for automatic renewal, they will need to complete a new application for coverage during the Open Enrollment Period; consumers can do this by using the "Report a Change" option in their Maryland Health Connection account.

If the consumer is eligible for automatic renewal, the Annual Renewal Notice will list the current coverage and the consumer's eligibility for coverage for 2019, assuming no additional changes are reported. If eligible for automatic renewal, the consumer will have three options:

- If the consumer has no changes to report and is satisfied with their current plan, the consumer's coverage will automatically renew without further action. However, it is always advisable for consumers to review the information in their application and the available plans to determine if their information is correct or if another plan would better meet their needs and budget. Consumers can review their renewal application starting on November 1 by logging into their Maryland Health Connection account and selecting their name in the upper right corner, then "Manage Account Settings," and then "View Application Details." Consumers can browse plans at https://secure.marylandhealthconnection.gov/AHCT/LandingPageCTHIX using the "Get an Estimate" feature.
- If the consumer has changes to report, or would like to shop for a different plan, the consumer will need to select "Change My Information" from their online account.
- If the consumer who is otherwise eligible for automatic renewal does not want 2019 coverage through Maryland Health Connection, the consumer will need to terminate their coverage before December 31. Until coverage is terminated, consumers will continue to be billed for coverage. The consumer can use the "End My Current Coverage" feature from their online account.

6.1.2 Special Enrollment Periods (SEPs)

A Special Enrollment Period is a time outside of the annual Open Enrollment Period during which a consumer may sign up for health coverage. A consumer may be eligible for a 60-day SEP through Maryland Health Connection after certain qualifying life events that involve a change in family status or loss of other health coverage.

6.1.2.1 Qualifying Life Events

There are a variety of life events and circumstances that may allow a consumer to enroll in a qualified health plan through Maryland Health Connection or change their current plan during a special enrollment period. Whether a consumer qualifies for a special enrollment period depends on the type of event and how it affects eligibility for coverage.

Examples of life events that may allow a consumer to enroll in coverage through Maryland Health Connection outside of the Annual Open Enrollment Period include:

- Getting married or divorced
- Having a child, adopting a child, or placing a child for adoption or in foster care
    - Becoming pregnant is not a qualifying life event which triggers a Special Enrollment Period. However, giving birth will qualify a consumer for an SEP. If a consumer is pregnant, the consumer should report this information to Maryland Health Connection as soon as possible because they may qualify for Medicaid. A consumer can apply for Medicaid at any point during their pregnancy.
- Certain changes in income – some examples include:
    - If a consumer is currently enrolled through Maryland Health Connection and their CSR Level changes as a result of an income change, they will be eligible to select a new plan
    - If a consumer's change in income results in the consumer no longer being eligible for Medicaid, the consumer will be eligible for an SEP in which to select a QHP
- Moving to or from Maryland, and certain moves within the state – if a consumer is moving within the state, the move must result in the consumer gaining access to plans not previously available to them in order for the consumer to be eligible to select a new plan
- Having a change in disability status
- Gaining or losing a dependent
- Certain losses of other health coverage (such as employer ending coverage, COBRA coverage period ends, or loss of job or employee leaving a job that provides coverage — but not termination for consumer's failure to pay plan premium)
- Becoming ineligible for Medicaid or MCHP
- Other changes that may affect eligibility include: change in tax filing status; change of citizenship or immigration status; incarceration or release from incarceration; change in status as an American Indian/Alaska Native or tribal status
- Certain errors or exceptional circumstances; these are reviewed on a case-by-case basis.

It is important to note that generally a consumer cannot qualify for a Special Enrollment Period if they lose their health coverage because they stopped paying their premiums. Also, there is no Special Enrollment Period available to people because they become ill, develop a chronic condition, or have an accident.

6.1.2.2 Special Enrollment Period Effective Dates

For most life events, if a consumer qualifies for a Special Enrollment Period to enroll in or change plans, and they report their new plan selection to Maryland Health Connection between the 1st and the 15th of the month, coverage will begin on the 1st of the following month. For example, if selection is made on July 8, coverage will begin August 1.

If a consumer reports their new plan selection to Maryland Health Connection between the 16th and the last day of a month, coverage will begin on the 1st of the next following month. For example, if selection is made on July 16, coverage will begin Sept. 1.

- For certain SEP-triggering life events, the plan will become effective following a different timeline.
    - In the case of a birth, adoption or placement in foster care, the plan selected through an SEP will take effect on the date of the birth, adoption or placement in foster care. For example, if the consumer has a baby on May 20 and selects a plan through Maryland Health Connection on June 1, coverage for the family will begin May 20.
    - In the case of marriage or loss of certain other health coverage that is considered minimum essential coverage, the plan selected through an SEP will take effect on the 1st of the following month after both plan selection is reported to Maryland Health Connection and actual loss of coverage or marriage date. For example, if employer-sponsored coverage is lost on June 10 and plan selection is made June 20, coverage will begin July 1.
        - Entering an incorrect loss of coverage date can have adverse effects on a consumer's enrollment. For example, if a consumer is losing coverage on June 30 and completes an application for coverage on June 20, with the loss of coverage date on the application listed as July 1 (rather than June 30), the result will be an August 1 effective date.

6.1.3 Termination of Coverage

If a consumer no longer wishes to be enrolled with Maryland Health Connection, they can voluntarily terminate their coverage at any time. The termination date of the plan will be the last day of the month in which the consumer requests termination. For example, if a consumer requests termination of coverage on June 10, coverage will end on June 30.

Consumers can terminate their coverage by taking one of the following actions:

- If the consumer wishes to terminate the entire policy, not just an individual member of the household, they can use the "End My Current Coverage" feature in their online account
- If the consumer wishes to terminate only one member of the household, when multiple members are enrolled in the plan, they should do so by taking one of the following actions:

    - The consumer can call the Consumer Support Hotline at 855-642-8572 and request termination;

- The producer can also call the Producer Support Hotline at 844-224-6761 to request termination

6.1.3.1 Termination Due to Death

If a consumer's coverage needs to be terminated due to death, the effective date of the termination will be the date of death. If a producer has a consumer that needs to be terminated due to death, the producer should escalate the case by following the instructions in Section 3.13.3.

In the event of death of the primary subscriber where other members are enrolled in a QHP, there may be a gap in coverage for the remaining household members. For example, if a primary subscriber passes away on June 20, the entire household will be terminated effective June 20. When the remaining household members reapply with a new primary subscriber due to a loss of coverage on June 20, they will not be reenrolled until July 1, leaving them with a gap in coverage from June 21 through June 30.

It's important to know that re-enrollment due to loss of the initial primary applicant will result in the insurance carrier resetting accumulators, such as deductibles and co-insurance.

6.1.4 Verification Documents

When an application is completed or a change is reported through Maryland Health Connection, certain information on the application may need to be verified.

If Maryland Health Connection is unable to verify the information provided in an application using information from the Federal Data Services Hub (FDSH) or other electronic data sources, the consumer will receive a notice by mail or in their online account's "My Inbox" requesting documentation to verify the information on the application is correct. The notice will give the consumer a deadline for returning the requested documentation. If the required documentation is not submitted by the deadline, the consumer's coverage may be terminated or APTC may be reduced to zero.

If a consumer is eligible for Medicaid, MCHP or MCHP Premium, and there is an outstanding identity or income verification document, the enrollment will remain in a pending status until the documentation is provided by the consumer and verified by the Maryland Health Benefit Exchange. Until the documentation is submitted and verified, the consumer will not be able to obtain services. If the documentation is not submitted by the deadline, the consumer's application will be cancelled.

6.1.4.1 Verification Documentation Submission

Verification documentation can be submitted in the following ways:

- (Preferred Method) Documents can be submitted via the "My Inbox" tab in the consumer's online account; a link will be available to upload the documentation if required
- Documents can be submitted with the free mobile app (Enroll MHC) using the camera of a mobile device (iOS or Android)
- If documents cannot be submitted online, the consumer may mail them to Maryland Health Connection, P.O. Box 857, Lanham, MD 20703; if provided by mail, the consumer

should include the bar-coded cover sheet that comes with the "Additional Verification Required" notice, otherwise the consumer's documents may not be timely processed

6.1.4.2 Acceptable Verification Documentation

If a consumer needs to submit verification documentation, information in the link below will provide the list of acceptable documents for each type of verification status:

- https://www.marylandhealthconnection.gov/get-answers/verifying-your-application-information/

In certain instances, a consumer may not be able to provide adequate proof of income, as described in the above "Proof of Income" link. If a consumer has no current income, or if the consumer is self-employed, the consumer can also provide one of the following affidavits as proof of income:

- Affidavit of Current Income: https://www.marylandhealthconnection.gov/assets/MHC_Affidavit_CurrentIncome.pdf
- Affidavit of Self-Employment Income: https://www.marylandhealthconnection.gov/assets/MHC_Affidavit_Self-EmploymentIncome.pdf

6.1.5 Reporting Changes

People often experience changes in their lives throughout the course of a year, *e.g.*, they may get married, have a child, or gain or lose employment. Certain changes must be reported via the consumer's online Maryland Health Connection account. These changes may result in the consumer being eligible for a different affordability program, or for more or less financial assistance. Some of these changes, if not reported, can have an adverse effect on the consumer's tax filing. A consumer should always "Report a Change" from their online Maryland Health Connection Account if the consumer:

- Gets married or divorced
- Has a child, adopts a child, or places a child for adoption or in foster care
- The consumer has a change in income
- Moves outside of Maryland, or somewhere else within the state
- Has a change in disability status
- Gains or loses a dependent
- Gains access to employer-sponsored coverage, Tricare, or Medicare
- Has a change in tax filing status
- Has a change in citizenship or immigration status
- Becomes incarcerated or is released from incarceration

6.1.6 Medicaid Enrollment by Producers

Producers may encounter consumers who are eligible for Medicaid and the household composition will determine next steps.

- If the entire household is eligible for Medicaid, the consumer should be referred to their local health department to complete their application and enrollment. Producers

should not enroll Medicaid-only households, and will not receive any compensation for assisting with these enrollments.
- Split households: If some members of the household are eligible for a QHP and others are eligible for a Medicaid program, enrollment for both programs should be completed.

6.1.6.1 Medicaid/MCHP Effective Dates

Consumers newly enrolling in Medicaid or MCHP will have an effective date the 1st of the month in which they apply. For example, if a consumer completes his application on June 10, the effective date of the coverage will be June 1.

Consumers newly enrolling in Medicaid or MCHP will also have the option to elect up to three months of retroactive claims coverage during the application process. Medicaid will pay for unpaid medical expenses for certain medical services that were incurred up to three calendar months prior to the month of the initial application, if the applicant was eligible for Medicaid during this retroactive period. The consumer may still be responsible for medical bills incurred during this period if they received services from providers who do not accept Medicaid payments.

If the option to elect retroactive claims coverage is not available, or is not chosen during the initial application, the producer should escalate the request following the instructions in Section 3.13.3.

6.1.6.2 Medicaid and MCHP Managed Care Organization (MCO) Selection

Following the submission of an application and verification of any requested verification documentation, a consumer's enrollment will read over to the Medicaid Management Information Systems (MMIS). Once the consumer's enrollment reads over to MMIS, the consumer will receive their red and white Medicaid card in the mail within 14 days. The consumer will also be able to choose an MCO once the application is completed and verified.

There are several ways a consumer can choose their MCO and primary care doctor:

- Visit MarylandHealthConnection.gov and log into the consumer's account.
- Download the free mobile app, Enroll MHC.
- Call the call center at 1-855-642-8572 (TTY: 1-855-642-8573).
- Request an enrollment kit be mailed (through the online account or by calling the call center).

If a consumer does not pick an MCO within 24 hours, they will be automatically assigned to one. Consumers who are enrolled in an MCO through auto-selection may request a change in MCO assignment during the first 90 days unless they are hospitalized. Newborns will be auto-enrolled in their mother's MCO. The newborn's MCO selection cannot be changed for 90 days.

MCOs are similar to the provider networks private insurance carriers use, and different healthcare providers participate in different MCOs. Consumers should check with their doctor or healthcare provider before selecting an MCO to determine in which MCO their doctor or healthcare provider participates, or use the search tool at https://encrypt.emdhealthchoice.org/searchable/main.action to find the doctors or healthcare providers who participate in each MCO.

Consumers can select from the following MCOs:

- Aetna Better Health of Maryland
- AMERIGROUP Community Care
- Jai Medical Systems
- Kaiser Permanente
- Maryland Physicians Care
- MedStar Family Choice
- Priority Partners
- UnitedHealthcare
- University of Maryland Health Partners

The following guide can be used to compare MCOs:
https://www.marylandhealthconnection.gov/assets/MCO-Comparison-Chart.pdf

When making a doctor's appointment, consumers should let the doctor's office know they are enrolled in Medicaid or MCHP, and provide the name of their MCO.

The consumer may change MCOs in annually during redetermination, or in select circumstances, such as combining all household members or children into the same MCO, or if the consumer moved and their current MCO does not provide service in the county where they now live.

6.1.6.3 Medicaid for Aged, Blind, and Disabled (ABD)

Individuals can qualify for Medicaid on the basis of being aged, blind, or disabled. These individuals cannot, however, apply for Medicaid using Maryland Health Connection.

Individuals who want to apply for Medicaid on the basis of being aged, blind, or disabled should be referred to their local health department or their local department of social services office to apply for benefits. Health Department and Social Services offices can be found at this link: https://www.marylandhealthconnection.gov/get-help-enrolling/ .

6.1.7 Remote Identity Proofing (RIDP)

Maryland Health Connection consumers undergo a process called Remote Identity Proofing early in the process of creating their application. They are presented with questions based on their credit history in order to verify they are who they claim to be. These questions are provided and administered by Experian, a credit reporting agency. If the consumer correctly answers the questions, their RIDP requirement is fulfilled and they can proceed with their application. If the consumer is unable to answer the questions correctly however, or if the consumer has no credit history on which to base the questions, they must satisfy the requirement in another way before they will be able to proceed with their application.

In the case of a consumer who answers their questions incorrectly, they may attempt to complete the requirement by phone with Experian. Maryland Health Connection will provide the consumer with the phone number to call and a special code to use for this purpose. If the consumer cannot complete RIDP on the phone, they will be required to provide proof of identity.

Consumers who are required to provide proof of their identity can meet this requirement in the following ways:

- Producers who verify the identity of a consumer in-person can call the Producer Support Hotline to have the application advanced. Once the application is advanced, the producer can pick up the application and proceed to help the consumer with enrollment.
- Consumers can visit a local Connector Entity, local health department, or a local social services office to have their identity verified in person; locations can be found here: https://www.marylandhealthconnection.gov/get-help-enrolling/
- Consumers can upload their proof of identity via their online Maryland Health Connection account, via the "My Inbox" tab
- Consumers can mail a copy of their proof of identity to Maryland Health Connection, P.O. Box 857, Lanham, MD 20703

It is important to note, if a consumer uploads their proof of identity or if the consumer mails the proof of identity, the consumer will not be able to proceed with their application until the documentation is verified by a Maryland Health Connection verification worker. This is why the preferred method is to use the Producer Support Hotline to advance the application after in-person identity verification.

It is also recommended if a consumer is going to go to a local Connector Entity or a Local Health Department to have their identity verified, to call ahead before going to ensure that someone with Worker Portal access will be available to verify their identity and advance the application.

Once the consumer's identity has been verified, the consumer will be able to proceed with their application on Maryland Health Connection.

6.1.8 Choosing the Primary Applicant

In most cases, when a consumer applies for coverage, the account holder (who defaults to the primary applicant) should be the household member the consumer wants as the contract holder with their insurance company.

Once the consumer is enrolled in a plan, the primary applicant cannot easily be changed; it is important to choose the appropriate primary applicant during the initial application process.

Some factors the consumer should consider when choosing the primary applicant include:

- The primary applicant does not need to be applying for coverage, but must be at least 18 years old. Generally speaking however, if there is an adult applying for coverage, the adult applying for coverage should be listed as the primary applicant. If the primary applicant is not seeking coverage, the second person listed in the household on the application will be considered the primary subscriber by the insurance company.
- If a consumer has more than one adult in their household applying for coverage, and the consumer expects one member of their household to end their coverage within the year (such as becoming eligible for Medicare, or enrolling through an employer), make the adult that will not be losing coverage the primary applicant.

- If the consumer's household has mixed immigration status, make the adult who is an U.S. citizen or lawfully present the primary applicant, even if that person is not seeking coverage.
- If the consumer is married and both spouses are citizens or are lawfully present, but only one of them is seeking coverage, make the person seeking coverage the primary applicant.
- If the consumer is seeking coverage only for a dependent child under 17, an adult must be listed as the primary applicant, even if the adult is not seeking coverage.

6.1.9 Entering Citizenship/Immigration Information

Consumers should be as accurate as possible when entering their citizenship or immigration information on Maryland Health Connection. Entering inaccurate citizenship or immigration information could result in unnecessary requests for verification documentation, or a consumer may receive an inaccurate eligibility determination.

One of the most common issues seen in regards to citizenship is consumers entering a status of "U.S. Citizen" instead of "Naturalized Citizen." While Naturalized Citizens are U.S. Citizens, it is important to note that the Federal Data Services Hub differentiates between the two. If a consumer's citizenship attestation is not verified and the consumer fails to submit the required verification document within the allotted time frame, their coverage will be terminated.

6.1.10 Enrolling Household Members in Multiple Plans

For a variety of reasons, some consumers may want to enroll some family members in one plan, and other family members in another plan. In order to accomplish this, consumers need to do the following:

- For each plan the consumer wants, an account/application will need to be created for the primary applicant of that plan; for example, if a husband and wife each want a separate plan, the husband will be the primary applicant/account holder on one application and the wife will be the primary applicant/account holder on the other application
- Husband should be marked "yes" for wanting coverage on his application only, and wife should be marked "yes" for wanting coverage on her application only
- Each application must still list all applicable household members and all applicable income

It is important to note when placing household members into more than one plan, that the tax credits available to the household will be split between the plans.

6.1.11 Children Aging Out of Coverage

6.1.11.1 Aging Out of QHPs

Children can enroll in a parent's QHP until they turn 26, even if they are:

- Married
- Not living with their parents (but if over 21, must live in Maryland or if out state, are temporarily living outside of Maryland and intend to return to Maryland such as when the child is attending school out of state)

- Attending school
- Not financially dependent on their parents
- Eligible to enroll in their employer's plan

If a child is enrolled in the family's QHP and turns 26, the child can remain on the plan until the end of the plan year. When the household renews coverage at the end of the year the 26 year-old child will not be included, but will receive a separate notice to visit Maryland Health Connection to create a new account and apply as a separate household.

6.1.11.2 Aging Out of Medicaid/MCHP

Dependent children eligible for, and enrolled in, Medicaid or MCHP are generally eligible until they turn 19. Leading up to the child's 19th birthday, the consumer will generally receive information explaining that the child will be aging out of Medicaid/MCHP. At this time, the child will be eligible for an SEP and the child can be enrolled in the following ways:

- The parent can "Report a Change" from their online account in order to enroll the child in their QHP. The consumer should list the loss of Medicaid coverage for the child in the SEP section of the application.
- If the child will file his/her own taxes in the upcoming year, and will not be claimed by the parents, the child can also complete a new account/application for his or her own health coverage. The child should list the loss of Medicaid coverage in the SEP section of the application. Remember, however, if the child's parents are enrolled in a QHP, the child is eligible to enroll in the parent's QHP until age 26.

6.1.12 Internal Revenue Service (IRS) Flag

If, at renewal, the household is determined ineligible for a QHP with financial assistance because, "we cannot determine if [their] tax household filed a [previous year's] federal tax return," this means the IRS has flagged the consumer. If the consumer is flagged by the IRS for not filing, or reconciling, the previous year's federal tax return, the consumer will not be able to enroll with an APTC until they have filed and/or reconciled the previous year's tax return with the IRS (the consumer may still enroll without assistance until the flag is cleared). Once the consumer files and/or reconciles the previous year's tax return with the IRS, and the flag is removed by the IRS, the consumer will be eligible to have financial assistance restored if they are actively enrolled at the time the flag is cleared. It is important to note that the IRS flag will not be removed until at least the end of the month after the consumer files/reconciles with the IRS, but it could take until the end of the subsequent month before the IRS flag is removed.

In the event that the consumer claims to have filed and reconciled their previous year's tax return, yet the consumer is still being flagged by the IRS, the consumer may complete the attestation on the income portion of the application and financial assistance will be restored. At the conclusion of open enrollment, all households who attested to filing/reconciling will be re-checked against IRS dat. If the flag persists, there eligibility will be re-determined without financial assistance for the remainder of the year.

6.1.13 Eligibility for Employer-sponsored Minimum Essential Coverage (MEC), TRICARE, and Medicare Part A

6.1.13.1 Eligibility for Employer-sponsored MEC

Consumers who are eligible for "affordable" MEC through their employer may be eligible to enroll in health insurance through Maryland Health Connection, however they will not be eligible for a QHP with financial assistance. Additionally, if the employer offers "affordable" MEC for the employee and also offers coverage for the spouse and children, the spouse and children will likewise be ineligible for assisted QHP coverage.

Employer coverage is considered affordable if the employee's share of the annual premium for self-only coverage is no greater than 9.69% of annual household income. Employer coverage also must meet some basic standards, known as providing "minimum value." Employer coverage provides "minimum value" if it covers 60 percent of health care costs on average. Consumers offered job-based coverage that's "affordable" and provides "minimum value" aren't eligible for an assisted QHP. Consumer's employers should be able to tell them if their plan meets this standard. The employer can fill out an Employer Coverage Tool at https://marketplace.cms.gov/applications-and-forms/employer-coverage-tool.pdf.

Note: Household members who are eligible for a Medicaid program are not disqualified on the basis of an offer of employer sponsored coverage.

6.1.13.2 Eligibility for TRICARE and Medicare Part A

Consumers who are eligible for TRICARE or premium-free Medicare Part A may be eligible to enroll in health insurance through Maryland Health Connection, however they will not be eligible for financial assistance. Consumers who are currently enrolled in TRICARE or premium-free Medicare Part A may not apply for coverage on Maryland Health Connection. Consumers who have not worked enough quarters to be eligible for premium-free Medicare Part A need to consider their options carefully. These consumers are best served with a referral to a local SHIP counselor to thoroughly review and discuss their options. Information about SHIP and county office contacts can be found here: http://www.aging.maryland.gov/Pages/StateHealthInsuranceProgram.aspx

6.1.14 Married Filing Separately

Consumers who will be filing "married filing separately" for the upcoming year, may be eligible to enroll via Maryland Health Connection, however they will not be eligible for an APTC.

There are exceptions to this however:

- Victims of spousal abuse
- Victims of spousal abandonment

If the consumer is living apart from their spouse and is a victim of domestic abuse, domestic violence, or spousal abandonment and wants to enroll in their own health plan separate from their abuser or abandoner, the consumer can indicate they are "unmarried" on their Maryland Health Connection application without fear of penalty for misstating their marital status.

6.1.15 Payments

6.1.15.1 QHP and Dental Binder Payments

Consumers enrolling a QHP via Maryland Health Connection are required to make their binder payment prior to the effective date of their policy. Consumers who fail to make a timely binder payment will not be reinstated unless the failure was due to Exchange or carrier error.

6.1.15.2 QHP Subsequent Payments – Enrolled with APTC

Consumers enrolled in a QHP with APTC will be given a grace period for subsequent payments as long as they made a timely binder payment. The grace period for subsequent payments for those enrolled in a QHP with APTC is 90 days. Once the consumer gets 90 days behind on their payments, the consumer's coverage will be terminated. Consumers who are terminated for non-payment of subsequent premiums will not be reinstated unless the failure to make a timely payment was due to Exchange or carrier error.

6.1.15.3 QHP Subsequent Payments – Enrolled without APTC

Consumers enrolled in a QHP without APTC will be given a grace period for subsequent payments as long as they made a timely binder payment. The grace period for subsequent payments for those enrolled in a QHP without APTC is 31 days. Once the consumer gets 31 days behind on their payments, the consumer's coverage will be terminated. Consumers who are terminated for non-payment of subsequent premiums will not be reinstated unless the failure to make a timely payment was due to Exchange or carrier error.

6.1.15.4 Dental Subsequent Payments

Consumers enrolled in a Dental plan will be given a grace period for subsequent payments as long as they made a timely binder payment. The grace period for subsequent payments for those enrolled in a Dental plan is 31 days. Once the consumer gets 31 days be hind on their payments, the consumer's coverage will be terminated. Consumers who are terminated for non-payment of subsequent premiums will not be reinstated unless the failure to make a timely payment was due to Exchange or carrier error.

6.1.15.5 MCHP Premium Payments

Consumers enrolled in MCHP Premium should receive a billing invoice from Medicaid. Consumers are required to make their payments by the invoice due dates. If a consumer has questions about MCHP Premium payments, the consumer should contact the MCHP Premium Case Management Unit at 410-767-6883 (toll-free: 1-866-269-5576).

6.1.16 Form 1095

Consumers enrolled with Maryland Health Connection at any point during the tax year will receive a Form 1095 at the end of the year. The Form 1095 is an IRS tax form. Like other tax forms consumers receive, the 1095 is generally sent out by the end of January each year for the previous year.

6.1.16.1 Form 1095-A

Form 1095-A is produced for any individual or family who enrolled in a QHP through Maryland Health Connection, for any period of time in the last tax year. It has information about the health insurance the consumer and their family members received through Maryland Health Connection. It also has information about the amount of any APTC that may have been paid to the consumer's health plan in the last year. Consumers will need the 1095-A when they file their taxes.

6.1.16.2 Form 1095-B

Form 1095-B is produced for any individual who enrolled in Medicaid or MCHP through Maryland Health Connection, for any period of time in the last tax year. It is an IRS tax form that serves as proof that a consumer met the Affordable Care Act requirement to have health coverage. Consumers will need the 1095-B when they file their taxes.

6.1.16.3 Form 1095 Not Received

If a consumer does not receive their Form 1095 by the end of the second week in February, there are a couple of possible solutions:

- Consumers can access and print their Form 1095 from their online Maryland Health Connection account; to do so, consumers should go to their "My Inbox" tab, select "View More" in the "Message Center," then locate the Form 1095 by scrolling through the pages in "My Messages"
- If a consumer cannot locate their 1095 via their online Maryland Health Connection account, the consumer will need to request a copy of their 1095 by contacting the Consumer Support Hotline at 855-642-8572

6.1.16.4 Form 1095 Corrections

If a consumer receives a Form 1095 they believe is incorrect, a corrected Form 1095 can be requested by contacting the Consumer Support Hotline at 855-642-8572. The MHBE will review the correction request and send out an amended 1095 if the correction request is validated.

6.1.17 Appeals

There may be times when a consumer is unhappy with the result of an eligibility determination or with the enrollment process and wishes to file an appeal. If a consumer is unhappy with any decision made by the Maryland Health Benefit Exchange, and they wish to file an appeal, the consumer should visit https://www.marylandhealthconnection.gov/appeals/ to obtain a Request for Case Review form.

Producers may help consumers complete and submit the Request for Case Review form, but the form should be signed by the consumer. If your consumer would like you to participate in the appeal, such as speaking with the appeals coordinator, obtaining information about the case or appeals status, advocating on the consumer's behalf, or attending any subsequent hearing, you should have your consumer complete and submit the Release of Information form found via http://www.marylandhbe.com/wp-content/uploads/2015/06/Release-of-Information.pdf.

It is important to note, during the application process, the consumer is asked if they have or would like to appoint an authorized representative. The producer should NOT be listed as the authorized representative except in very rare circumstances (e.g., you are helping your adult, disabled nephew enroll in coverage). Authorized representative in the context of the Maryland Health Connection application has a specific legal purpose which is not appropriate for most

producer-client relationships. If a consumer would like you to participate in their appeal, they should NOT list you as their authorized representative; they should instead just complete the Release of Information form and submit the Release with their Appeals request.

6.2 SHOP Enrollment

As a state-based marketplace, the Maryland Health Benefit Exchange is responsible for the development and operation of a Small Business Health Options Program (SHOP) with these required functions:

- Certification of SHOP Qualified Health Plans (QHPs) and Qualified Dental Plans (QDPs)
- Determination of Employer Eligibility to Purchase SHOP QHPs and QDPs

MHBE offers health insurance options for small employers who provide health insurance to their employees. These small employers may qualify for federal tax credits to lower costs on employee health benefits. For SHOP purposes, a small business is defined as having 50 or fewer full time equivalent (FTE) employees.

6.2.1 SHOP Direct Enrollment

As of July 1, 2018, MHBE implemented a SHOP Direct Enrollment Process with the carriers.

New SHOP Business:

SHOP Eligibility is determined by MHBE when an application is submitted via our website (visit https://www.marylandhealthconnection.gov/small-business/shop-eligibility/). Participating SHOP insurance carriers will assist producers and employers with plan implementation. Please refer to the contact information and instructions provided by Maryland SHOP. Please contact Maryland SHOP via email at mhbe.shop@maryland.gov with any questions.

Renewing SHOP Business:

A new SHOP Eligibility Determination is not required for all renewing SHOP Business. A qualified employer may continue to participate in the SHOP if it ceases to be a small employer in accordance with 45 CFR § 155.710 (according to 45 CFR § 157.200b). Pursuant to 45 CFR § 155.710d, the SHOP must treat a qualified employer which ceases to be a small employer solely by reason of an increase in the number of employees of such employer as a qualified employer until the qualified employer otherwise fails to meet the eligibility criteria of this section or elects to no longer purchase coverage for qualified employees through the SHOP.

MD SHOP requires an employer to submit a new eligibility application for changes such as:

- Terminating offers of coverage to employees maintaining full-time status
- Growing to be a large employer without having maintained continuous SHOP coverage
- Moving its principal business address or eligible employee worksites out of the SHOP service area.

Employers must submit a new application to the SHOP if the employer makes a change that would end its eligibility under the requirements of 45 CFR 155.710(b) or withdraw participation with the SHOP within 30 days of said change.

Employer groups renewing prior to September 30, 2018 will be renewed, administered and billed through the prior SHOP Administrator, BenefitMall until their next renewal date. Employer groups renewing on and after October 1, 2018 will be transferred to direct business at their chosen SHOP insurance carriers.

Participating SHOP carriers may require an active SHOP renewal during the transition period from the SHOP Administrator, BenefitMall to Direct Enrollment. Employers and their authorized producers should contact the participating carriers to renew their SHOP benefits and actively renew at the carrier, if required.

6.2.2 SHOP Eligibility

To be eligible to enroll in SHOP, employers must:

- Have a principal business address within Maryland, or you can offer coverage to each eligible employee through the SHOP Marketplace serving that employee's primary worksite.
- Have at least one common-law employee on payroll (not including a business owner or sole proprietor or their spouses if they're on payroll). For the definition of a common-law employee, visit the IRS website at http://www.irs.gov/Businesses/Small-Businesses-&-Self-Employed/Employee-Common-Law-Employee.
- Employ 50 or fewer full-time equivalent (FTE) employees, including part-time employees. To calculate FTEs, please use the Full-Time Equivalent Calculator at https://www.healthcare.gov/shop-calculators-fte/. Please note that this number will change to 100 FTEs on January 1, 2016.
- Offer SHOP coverage to all full-time employees (30+ hours per week). Please note: Employers may also offer coverage to part-time employees, however they must offer SHOP coverage to all full-time employees.

The following individuals are not considered employees and should not be counted:

- Owners of the small business, such as sole proprietors, partners, shareholders owning more than 2% of an S corporation or more than 5% of a C corporation
- Spouses of these owners
- Family members of these owners, which include a child, grandchild, sibling or stepsibling, parent or ancestor of a parent, a step-parent, niece or nephew, aunt or uncle, son-in-law or daughter-in-law, father-in-law, mother-in-law, brother-in-law or sister-in-law
- Spouses of any of these family members

It is also important to note, even though a business may be eligible to enroll in SHOP, that doesn't necessarily mean the business is eligible for the Small Business Health Care Tax Credit.

6.2.3 SHOP Tax Credit

By purchasing a SHOP-certified QHP, employers may be eligible for a tax credit worth up to 50% of the amount contributed to employee health insurance premiums (35% for tax-exempt small businesses). This credit can be claimed for any two consecutive taxable years.

To estimate the amount of the employer's potential tax credit, use the SHOP Tax Credit Estimator at https://www.healthcare.gov/shop-calculators-taxcredit/ .

6.2.4 SHOP Participation Requirements

In most cases, employers must have a minimum participation rate of 75 percent in order to purchase insurance in the SHOP. For employers opting for the employee choice coverage model, the group must have 75 percent of its employees participating when aggregated across all carriers. You will learn about employee choice in just a moment.

Between November 15th and December 15th each year, the minimum participation rate requirement is waived, meaning there is no minimum participation requirement during this period.

Minimum participation rate calculations will take into account employees that have coverage elsewhere. Generally, employees with other group coverage (e.g., from a spouse, other group coverage, a parent plan, and those with public coverage, such as Medicare or Medicaid) will be excluded from minimum participation rate calculations. Employees with individual coverage, including Individual Marketplace coverage, will be included in minimum participation rate calculations as well as Cobra members.

6.2.5 SHOP Coverage Models

Small businesses that purchase coverage through the SHOP have the option of choosing between two coverage models for their employees:

- Employer Choice – Small employers select one carrier and allow employees to choose from among the plans offered by that employer across metal levels.
- Employee Choice – Small employers select up to two consecutive metal levels of coverage and employees may choose any plan within those levels from any carrier.

6.2.6 Employer Contribution Methods

A qualified employer may choose to contribute toward employees' premium payments by selecting a reference plan on which the contributions will be based and selecting one of the following methods:

- Percent contribution – In this method, the employer pays a fixed percentage of the premium of the reference plan based on the coverage level selected by the member and the member's job classification.
- Employees pay the same amount – In this method, the employer uses the reference plan they select to determine a set amount that employees will pay towards their total monthly premium based on designated employee tiers. Each employee within a tier pays the same monthly dollar amount. The employer pays the balance premium.

Employers are not required to contribute toward their employees' premium but they will not be eligible for tax credits unless they contribute at least 50 percent of the total premium cost.

6.2.7 SHOP Enrollment Process

SHOP New Business

The first step in enrolling a small business in SHOP coverage is to submit a SHOP Eligibility Application on the Maryland Health Connection website at this link: https://www.marylandhealthconnection.gov/small-business/shop-eligibility/.

If Maryland SHOP determines that the business is eligible to participate, they will provide a notice of eligibility for the employer.

If the employer is deemed ineligible, Maryland SHOP will provide the employer with notice of eligibility denial and appeal rights.

Maryland SHOP will provide these notices to both the employer and any designated authorized producer.

Next, the Employer (who is working with a producer) will make several important decisions regarding their SHOP coverage:

- Select the dates for Employee Open Enrollment
- Select the coverage model (Employer Choice vs. Employee Choice)
- Select the plans to be offered to their employees
- Select the contribution model and reference plan
- Select the waiting period for new hires

An employer and their producer can obtain SHOP plan information and quotes by contacting the new business department of the participating carriers. Contact information is provided in the Notice of Eligibility provided to the employer and designated authorized producer. A SHOP Quoting Tool in an Excel format has been provided via email to authorized SHOP producers. The SHOP Quoting Tool will be posted online for use by employers and producers.

Next, the Employer holds its Open Enrollment for employees. Once all the employee elections are made, the Producer and Employer provide the enrollment paperwork, including all employee applications, to the chosen participating SHOP carriers with a binder payment. The SHOP carriers then works to determine if the employer group has met their carrier guidelines, including eligibility of employees.

The cut-off date for new SHOP business is the 15th of the month to be effectuated on the 1st of the following month. Group set-up information submitted between the 16th of the month and the end of the month will be effectuated on the 1st of the second following month.

SHOP Renewal Business

Employer groups renewing prior to September 30, 2018 will be renewed, administered and billed through the prior SHOP Administrator, BenefitMall until their next renewal date. Employer groups renewing on and after October 1, 2018 will be transferred to direct business at their chosen SHOP insurance carriers.

Employers and their producers should contact their chosen SHOP insurance carriers to renew benefits, even if remaining with the same plans. The participating SHOP insurance carriers will

assist these groups to maintain their SHOP coverage and/or make renewal changes. The participating SHOP carriers will administer and bill the employer's SHOP coverage.

6.2.8 SHOP Group Maintenance

Employer groups remaining (until their next renewal) with the former SHOP Administrator, BenefitMall will be managed by BenefitMall. For groups that have transferred to direct enrollment with the participating SHOP carriers, the insurance carriers will manage the ongoing maintenance of SHOP group. These ongoing management functions include adding and removing employees from coverage, notices, billing, and collection of premium. If an Employer fails to pay the premium on time, the SHOP Administrator and/or the SHOP insurance carrier also processes the cancellation of coverage.

6.2.9 Broker of Record Updates

Employers are able to change their Producer of Record annually at the time of renewal. This can be done via the SHOP insurance carriers.

CHAPTER 7 – PII

7.1 Definition

During the enrollment process, producers are on the receiving end of information from consumers. This information will relate to personal identity, income and other information. Much of the information received by producer is considered Personally Identifiable Information (PII).

PII may include, but is not limited to:

- First and last name
- Address
- Date of birth
- Social Security Number
- Email address
- Phone number
- Insurance/Medicaid ID number
- Passport/alien number
- Place of employment
- Income information

7.2 Producer Responsibilities

Producers have several responsibilities regarding PII. These responsibilities include, but are not limited to, protecting consumers' PII from unauthorized use, access and disclosure. Producers should refer to their Non-Exchange Entity Agreement for a full list of their responsibilities regarding PII. If a producer needs a copy of their signed Non-Exchange Entity Agreement, they can login to Salesforce LMS via https://mhbe.force.com/training/CustomCommunityLogin.

7.3 Electronically Transmitting PII

When communicating by email with Maryland Health Benefit Exchange about a consumer, Authorized Producers must take steps to protect the consumer's privacy:

- When communicating by email, Identify consumers by Person ID or Application ID or household member status (husband, wife, dependent, etc.)
- Instead of emailing consumer details, call the Producer Support Hotline at 844-224-6761

7.4 PII Breach Penalties

Producers who violate the terms of the Non-Exchange Entity Agreement may be subject to fines, legal action, and/or the revocation of their Producer Authorization.

CHAPTER 8 – Additional Questions Not Covered Elsewhere in This Manual

8.1 What Is the Penalty If My Consumer Doesn't Have Health Coverage?

There is no penalty for 2019. For information regarding IRS penalties for those that don't have health coverage for 2017 or 2018, please visit https://www.healthcare.gov/fees/fee-for-not-being-covered/ .

8.2 My Symantec ID Changed. What Should I Do?

If a producer's Symantec ID changes for any reason (i.e. the producer changed phones, the producer downloaded Symantec VIP Access on their laptop and no longer wants the application on their phone, etc.), the producer will need login to Salesforce LMS via https://mhbe.force.com/training/CustomCommunityLogin and update the existing, approved application.

Symantec VIP Access can be downloaded in the following ways:

- The Mobile Symantec VIP Application can be easily downloaded from the App Store on an iPhone, Samsung, iPad, or other smart phone or tablet by searching for "Symantec VIP"
- The Mobile VIP Application can also be downloaded via the following link: https://vipmobile.verisign.com/home.v
- The Symantec Desktop Application can be downloaded via https://idprotect.vip.symantec.com/desktop/home.v

8.3 How Do I Log into My Producer Portal on marylandhealthconnection.gov ?

Producers can log into their Producer Portal by doing the following:

- Go to marylandhealthconnection.gov
- Click on "Enroll Now or Log In"
- Click on "Proceed"
- Click on "Sign In"
- Enter your User ID and Password
- Enter the security code from your Symantec VIP Access application

8.4 Can an Emancipated Child Enroll in Coverage on Maryland Health Connection?

Yes, an emancipated child can enroll in coverage. Maryland Health Connection however does not permit children under the age of 18 to be the primary applicant. If a child between the ages of 16-18 is an emancipated minor, the child must designate an adult to be the primary applicant. If the designated adult does not want coverage, this individual will click "not seekng coverage" at the beginning of the application. If the child between the ages of 16-18 is a parent, the child may enroll her newborn in coverage.

8.5 Can an Individual Who Is Homeless Enroll in Coverage on Maryland Health Connection?

Yes, an individual who is homeless can enroll in coverage. All applicants are required to list a physical address on their application however. A homeless applicant with no physical address should use the address of their Local Health Department. Local Health Department locations can be found here: https://www.marylandhealthconnection.gov/get-help-enrolling/ .

8.6 My Consumer Lives Outside of Maryland, but Is Still a Maryland Resident. Can He/She Apply for Coverage on Maryland Health Connection?

Yes, consumers living outside of Maryland who are still Maryland residents, can apply for coverage on Maryland Health Connection. The consumer will need to enter his/her physical Maryland address in the required address field on their application, and their out-of-state mailing address in the optional mailing address field.