MARYLAND HEALTH BENEFIT EXCHANGE RESPONSES TO INFORMAL PUBLIC COMMENTS ON PROPOSED COMAR 14.35.15 (version 1)

The following chart summarizes informal public comments submitted to Maryland Health Benefit Exchange (MHBE) by April 27, 2016 regarding proposed COMAR 14.35.15 and MHBE's response to each comment. Comments are organized by regulation (identified in the Source Comment column) and the commenting individual and/or organization is listed in the "Source" column (please refer to Source Key below for abbreviations guidance). Accepted comments are incorporated into the revised and redlined version two of proposed COMAR 14.35.15, which is also being shared at this time. MHBE will address these comments at the June 13, 2016 public meeting.

Additional written comments may be submitted to MHBE regarding proposed COMAR 14.35.15 version 2 by June 6, 2016 at mhbe.policy@maryland.gov if the interested party wishes to comment in writing prior to the meeting. Written comments will also be accepted after the meeting until June 24, 2016.

Source Key

Carefirst = CareFirst BlueCross BlueShield	**HEAU = Office of Attorney General, Health Education and Advocacy Unit**	**League = The League of Life and Health Insurers of Maryland**	**MIA = Maryland Insurance Administrat**

Summary of Comments Received and MHBE Response to Comments

Source	**Comment**	**MHBE Response**
MIA	Throughout **14.35.15** there are many additional references to the defined terms "qualified individual" and "enrollee." Note that due to the way these terms are defined in the proposed draft of COMAR 14.35.01.02, the applicability of any provision that uses these terms will be limited to the Individual Exchange. Conversely, it seems that any provision that does not use these terms would be applicable to both the Individual Exchange and the SHOP	This chapter is only intended to address the Individual Exchange. All SHOP regulations will be addressed in separate chapters. Any references to SHOP, employee etc removed. Scope updated.

Source	Comment	MHBE Response
	Exchange. For most of the provisions that use the terms “qualified individual” and “enrollee,” it is unclear if the SHOP Exchange was deliberately excluded, or if this was simply an oversight. On the other hand, some of the provisions that do not use these terms appear to be intended only for the Individual Exchange, even though the regulatory language would technically make the requirement applicable to both Exchanges. The entire regulation should be examined to determine if the text accurately conveys the intended applicability to the Individual Exchange, the SHOP Exchange, or both. Particular attention should be given to all references to “qualified individual” and “enrollee,” and if the applicable provisions are intended to apply to the SHOP Exchange in addition to the Individual Exchange, appropriate revisions will be needed.	
MIA	**14.35.15.01**, the last sentence states that the chapter does not apply to certification of individual health benefit, dental or vision plans. We believe this is because the chapter discusses certification on the carrier level, rather than the plan level. If this is the case, should the sentence also mention small employer plans?	This chapter only addresses certification at the carrier level. Clarification edits included in the Scope to address that qualified plan certification is addressed in Chapter 16.
Carefirst	**14.35.15.02** Many of the definitions in .02 appear to summarize or paraphrase federally defined terms or operational terms. However, they do not fully capture the details of the federally defined terms or the operational nuances in them. CareFirst therefore recommends that the definitions either mirror the federal terms merely cite to them. Failure to make either modification, however, will is likely to cause unnecessary conflicting application of the governing laws and significant confusion for all stakeholders.	Definitions have been reviewed and edited to match federal and state provisions where the same terms are used.
HEAU	**14.35.15.02** - Does the non-exchange entity agreement only contain privacy and security provisions?	The NEAA only pertains to privacy and security requirements.
MIA	**14.35.15.02(B)(6)**, “Insurance Article” should be replaced with “Health-General Article.”	Edit incorporated.

Source	Comment	MHBE Response
MIA	**14.35.15.02(B)(8)**, the term "member" is used for the first time, and is not defined in Chapter 15, or in the proposed draft for the general definitions section of COMAR 14.35.01.02.	Definition of member added to Chapter 15.
MIA	**14.35.15.02(B)(8)**, the acronym "MIA" is used for the first time, but is not defined or spelled out ("HHS" is also used, but this acronym is already defined in COMAR 15.35.01.02).	Definition of MIA added to COMAR 14.35.01.02.
MIA	In C**OMAR 14.35.15.02(B)(10)**, the "MIA" is listed as one of the entities that receives the "SERFF Binder." The MIA does not receive the SERFF Binder (no individuals at the MIA even have access to the "Plan Management" tab in SERFF).	Edit incorporated to remove MIA from definition.
MIA	**14.35.15.03(B)**, it seems that subsections (2) and (3) should be deleted. The requirements described in these subsections are already captured by subsection (1). In Maryland, a carrier with a Certificate of Authority would automatically satisfy subsections (2) and (3).	Edit incorporated to remove (2) and (3).
MIA	**14.35.15.03(B)(1)**, it seems a reference should be added to a "dental plan organization" authorized under Title 14, Subtitle 4 of the Insurance Article. Every other type of carrier that may participate on the Exchange is already listed.	Edit incorporated.
MIA	**14.35.15.03(B)(5)**, the term "dental plans" is used for the first time, and is not defined in Chapter 15, or in the general definitions section of COMAR 14.35.01.02.	Definition for QDP, dental plan and SADP added to COMAR 14.35.01.02.
Carefirst	**14.35.15.03(B)(6) and (7)** require carriers to sign a carrier business agreement and non-exchange entity agreement, each in the form designated by the Exchange. Carriers should have the right to review and comment on any agreement with the Exchange before signing. As the carrier business	The agreement is a standard agreement that mirrors the approach taken by DHMH with the Medicaid provider agreement (See e.g., COMAR 10.09.36.03A(6)). The agreement is a standard agreement largely dictated by law. MHBE does not have any intention, absent a change in law, to amend the

Source	Comment	MHBE Response
	agreement also only acknowledges a carrier's willingness to comply with applicable laws, it is not clear why carriers have to sign such an agreement.	current agreement except that it may incorporate operational requirements, such as the carrier reference manual, into the carrier business agreement in future iterations.
MIA	**14.35.15.03(B)(8)**, it appears the text “agree to” should be inserted prior to “retain records.” The retention of records related to participation in the Exchange would be prospective from the date the carrier applies for certification from the Exchange. At the time of application, a carrier could only agree to begin retaining the records from that point forward.	Edit incorporated.
MIA	**14.35.15.03(B)(8)**, it appears the regulation should specify the date from which the 10 year period for retaining records is measured.	Mirrors federal requirement; however, edit incorporated to reflect “date of creation of record”.
Carefirst	**14.35.15.03(C)** requires carriers to remain as authorized carriers until their certification expires or the Exchange suspends or revokes their certification. Carriers have the right, however, under State law not to participate on the individual and SHOP Exchange (subject to a 5 year ban on participating in that market). MD. CODE ANN, INS. §§ 1212, 1308(c), 1409. This is also recognized in the last two versions of carrier business agreements the Exchange provided carriers. .03(C) should be amended to recognize that carriers have this right.	Edit incorporated.
MIA	**14.35.15.03(C)**, the cross-reference to “Regulation .08” appears incorrect. Under the draft regulations being reviewed, Regulation .08 of Chapter 15 does not discuss suspension or revocation of a carrier’s certification.	Cross-reference to 31-115(k) added.
MIA	**14.35.15.03(D)**, the text “undergoes a change of ownership as recognized by the State in which the carrier offers the qualified plan” is unclear. We suggest replacing this text with “merges into or is acquired by another entity and the merger or acquisition is approved by the Commissioner,” to be consistent with the types of carrier organizational changes recognized in Maryland. In subsection (2), “new owner” and “change of ownership” should then be	Edits incorporated.

Source	Comment	MHBE Response
	replaced with "new entity" and "merger or acquisition," respectively. In subsection (3), "new owner" should be replaced with "new entity."	
HEAU	**14.35.15.03(D)** - Shouldn't a new Carrier Business Agreement be furnished?	The CBA is listed as requirement for certification.
Carefirst	**14.35.15.04(B)(4)** requires carriers to provide the Exchange a list of its subcontractors. This is overly broad as carriers may have hundreds of subcontractors that don't perform any functions related to exchange enrollment or billing. The regulation should be amended to clarify that the list of subcontractors is limited to only those primary subcontractors that perform Exchange enrollment and billing functions.	Replaced "List of subcontractors" with: "a suspension and debarment affidavit as specified under State Finance and Procurement Article, §16-311, Annotated Code of Maryland".
MIA	**14.35.15.04(D)**, the Exchange imposes a requirement on itself, but the regulation does not explain what happens if the Exchange does not fulfill its obligation. It is very unusual for a regulator to place a requirement on itself in regulations that the regulator will be enforcing. However, if the intention is to retain this requirement, the regulations should be amended to indicate what will happen if the Exchange misses its self-imposed deadline. For example, would the application be deemed approved in this situation?	Edit not incorporated at this time.
HEAU	**14.35.15.05** - These regulations specifically require a carrier to process enrollment files from the Exchange within 24 hours but they do not specifically require the carrier to report back errors in the transaction. This should be added with a timeframe specified.	Edit incorporated as newly proposed: "If an authorized carrier cannot comply with §F of this regulation, the carrier shall notify the Exchange within 24 hours of receiving the enrollment file that it cannot be processed, including the reason for the delay."
MIA	**14.35.15.05(B)**, the term "broker" is used for the first time, and is not defined in Chapter 15, or in the proposed draft for the general definitions section of COMAR 14.35.01 .02.	Broker amended to "insurance producer" to capture pre-existing definition in COMAR 14.35.01.02 for insurance producer.
Carefirst	**14.35.15.05(B)** requires carriers to offer the same broker compensation for qualified plans offered on and off Exchange. The regulation does not account	Edit incorporated.

Source	Comment	MHBE Response
	for the fact that carriers offer different broker compensation in the individual and small group markets. The regulation, however, would require the same compensation across all market segments. The regulation also does not take into consideration that brokers in the small group market may be third party administrators that the Exchange contracts with and compensates for performing SHOP functions. Carriers should not have to compensate these brokers for functions the Exchange is already pays for. The regulation should be modified to reflect all of these nuances.	
Carefirst	**14.35.15.05(C)** requires carriers to comply with applicable State marketing laws. This provision is not necessary as it is duplicative of the obligations carriers already have to comply with.	(1) Amended to reflect that the standards may be created jointly with MIA. The Exchange is obligated to review this requirement under 45 CFR 156.220 and 225.
MIA	**14.35.15.05(C)**, the reference to health "insurance" carriers is inappropriate for many dental plan organizations and all health maintenance organizations. It seems the text should refer generally to "carriers."	Edit incorporated.
MIA	**14.35.15.05(C)** discusses carrier conduct with respect to marketing. Is §C intended to set forth the fair marketing standards developed jointly by the Exchange and the Commissioner, as described in §31-115(k)(2)(x) of the Insurance Article?	(1) revised to include 31-115(k)(2)(x).
MIA	**14.35.15.05(C)(1)**, please note that §§27-202 – 27-205 of the Insurance Article only apply to insurers, nonprofit health service plans, and dental plan organizations. The applicable citation for health maintenance organizations is §19-729 of the Health-General Article.	(2) revised to include reference to insurers and nonprofits. (3) added to include reference to 19-729 for HMOs. DPOs are not addressed in this chapter.
Carefirst	**14.35.15.05(D)** requires carriers to comply with applicable Exchange regulations. This provision is not necessary as it is duplicative of the obligations carriers already have to comply with.	The Exchange is obligated to review this requirement under 45 CFR 156.220 and 225.

Source	Comment	MHBE Response
MIA	**14.35.15.05(D)**, the reference to "Subtitle 35 of Title 14" does not specify the applicable legal or regulatory code. It seems a reference should be added to the Code of Maryland Regulations.	.05(D) removed.
Carefirst	**14.35.15.05(D)(3)** requires carriers to follow the standards m the Carrier Reference Manual and System Companion Guide. .05(D)(3) is confusing, as it requires carriers to comply with Subtitle 35 of Title 14 (a regulatory reference), as provided through the Carrier Reference Manual and System Companion Guide. It is unclear how a carrier can comply with regulations through a Manual or Guide. In addition, the Carrier Reference Manual has not been updated since October 2014 and contains references that now conflict with these draft regulations. For example, the Carrier Reference Manual requires a binder payment in full before coverage will be effectuated, which does not account for the exception proposed in regulation where enrollees renew into the same plan or product. Similarly, the 834 companion guide was last updated in October 2015, and contains references that conflict with these new regulations. The regulation therefore establishes the likelihood that carriers will have conflicting regulatory and Manual/Guide requirements to comply with. Moreover, as the Manual and Guide have general applicability, they are subject to the Maryland Administrative Procedure Act's notice and public comment requirements. MD. CODE ANN, STATE GOV'T. § 10-101, et. seq. The regulation should be amended to reflect this requirement on the Exchange.	.05(D) removed.
MIA	1**4.35.15.05(E)**, there is a reference to "qualified individuals" enrolling in the Individual and SHOP Exchanges. However, in the proposed draft of COMAR 14.35.01.02 (B)(45), "Qualified Individual" is defined with respect to the Individual Exchange only. It seems that either the definition of Qualified Individual or COMAR 14.35.15.05(E) should be revised to correct this inconsistency.	Scope section amended to clarify this Chapter does not apply to SHOP carrier or plan certification and "qualified employees" and "and SHOP" removed from the draft

Source	Comment	MHBE Response
Carefirst	**14.35.15.05(E) and (F)** require carriers to "allow" qualified individual to enroll in plans during open enrollment or special enrollment periods. These regulations appear to require carriers to accept all qualified individuals' enrollment during these periods as is required by the guaranteed availability rules, which already require carriers to accept all permissible enrollments. See 42 USC § 300gg-1; MD. CODE ANN. INS.§§ 15-137.l(a)(20), 15-1410(b).	Scope section amended to clarify this Chapter does not apply to SHOP carrier or plan certification and "qualified employees" and "and SHOP" removed from the draft
MIA	**14.35.15.05(G)**, the cross-reference to COMAR 14.35.14.04B-D appears incorrect. Under the draft regulations being reviewed, the cited regulations discuss enroll-initiated termination of coverage, rather than effective dates of coverage.	Updated 14.35.14 incorporated.
Carefirst	**14.35.15.05(G) and (H)** require carriers to implement the effective dates of coverage established by the Exchange and to process enrollment files from the Exchange within 24 hours of receipt. This is only possible if the enrollment file from the Exchange is accurate and contains all necessary information, and if the effective dates of coverage are in compliance with federal and state law. On multiple occasions, including as recently as April 8, 2016, CareFirst has questioned this requirement as it does not take into account the time to correct defects. This timeline also does not take into consideration weekends and holidays. The regulation should be modified to reflect this. Moreover, if carriers are required to process files from the Exchange within a given timeframe, the Exchange should similarly be required to develop service level agreements and be held to the same timeframe to process any files back from carriers that reflect an Exchange error.	Edit incorporated as "G. Upon acceptance of the enrollment file, the authorized carrier shall immediately provide an acknowledgement that the file has been accepted by the authorized carrier via the electronic data interchange. H. If an authorized carrier cannot process an enrollment file within 24 hours, the carrier shall notify the Individual Exchange within 24 hours of accepting the enrollment file that it cannot be processed, including the reason for the delay." Carriers should send the acknowledgement - either a 999 or TA1 - under the current procedure immediately following processing of the file. This would occur prior to the additional information about the error reason. MHBE will work with carriers to implement this requirement, however, it is MHBE's understanding that all but one carrier is able to meet this requirement currently.

Source	Comment	MHBE Response
Carefirst	**14.35.15.05(J)** requires a carrier to accept and process enrollment for a qualified individual that does not include a Social Security Number. On multiple occasions, CareFirst has pointed out that SSN's are required for 1094/1095 reporting and all SSNs need to be collected and submitted on 834s. CareFirst recently submitted comments to the Exchange on April 8, 2016 on this issue as well, when the Exchange proposed this same requirement for the 834 Companion Guide. The Exchange should also have to develop a process to notify carriers when no SSN is available as opposed to a consumer opting out of providing the information	Provision moved to enrollment - COMAR 14.35.07.11. An SSN is only required as part of the application if: 1) For a non-applicant, an individual is a tax filer who attests to having an SSN and filing a tax return for the year for which tax data would be used to verify household income and size (45 CFR 155.305(f)(6)) and 155.310(a)(3)(ii). 2) For an applicant, if the applicant has an SSN (45 CFR 155.310(a)(3)(i). If an SSN is not available, a DOB shall be used for the 1094/1095: Under 26 CFR 1.36B-5(c)(1)(i), (ii) and (vi), if a taxpayer identification number is not available, the Exchange may report the DOB for the tax filer/responsible adult, spouse and other covered individuals. This information is reiterated in the Form 1095A instructions from the IRS: https://www.irs.gov/pub/irs-pdf/i1095a.pdf.
MIA	**14.35.15.05(J)**, it appears the reference to “health benefit plan” in the second line should be replaced with “carrier.” “Health benefit plans” are not entities that would be processing enrollments.	Edit incorporated.
Carefirst	**14.35.15.05(L)** requires carriers to apply accumulators to remaining family members if the subscriber is terminated. As CareFirst has previously advised the Exchange in January 2016, it is unclear who the "policyholder" would be under Maryland law if the subscriber terminates his or her enrollment. This is particularly complicated when there is no remaining adult on the plan, and the policy may need to then be split into multiple "child only" plans and any accumulated cost-share would need to be allocated accordingly. In addition, APTC eligible households are concerning if carriers are terminating the	Provision moved to termination chapter - COMAR 14.35.14. MHBE provided additional guidance within the Chapter 14 comments and in follow up to the May 17 meeting on Chapter 14 to stakeholders regarding its proposed amendments to this requirement.

Source	Comment	MHBE Response
	subscriber, as carriers cannot re-determine households' APTC eligibility. This regulation should not be pursued without the MIA's review and input. The Exchange should also define how the carrier can determine whether the policy sent requires an accumulator credit and how to distinguish a child only policy or new policy from this type of change. As noted before, carriers will need detailed requirements in order to code and test this change. The Exchange must incorporate detailed testing with plans once the technical and operational requirements have been clearly articulated and a project schedule has been created.	
MIA	**14.35.15.05(L)**, it appears that text such as "before receiving an instruction from the Exchange to terminate coverage" should be add after "A carrier shall terminate an enrollee's coverage." Under the draft regulations being reviewed, COMAR 14.35.14.06 describes the only circumstances where the carrier may initiate termination of coverage on its own. However, COMAR 14.35.14.05 describes additional circumstances where the carrier must terminate coverage after receiving instructions from the Exchange.	Under I, reference edited to incorporate COMAR 14.35.14.04-.07. MHBE cannot otherwise locate the text referred to in this comment.
MIA	**14.35.15.05(L)** appears out of place in Regulation .05, which otherwise discusses carrier conduct conditions for participation in the Exchange. It appears that it may be more appropriate to include §L in the proposed draft of COMAR 14.35.14, which discusses termination of coverage. We believe §L is intended to address continuity of care situations for individuals covered under a family plan, when the primary enrollee is terminated from the Exchange, but the remaining family members continue to be eligible for coverage through the Exchange. However, there is no context for §L within Regulation .05. It appears additional text is needed for clarity in order to properly frame the situation that §L is intended to address. For example, §L does not clearly indicate that it only applies to an individual covered under a family plan, when the carrier terminates the plan for the remaining family members due to the ineligibility of the primary enrollee. The text refers to an "original contract"	Moved to COMAR 14.35.14.

Source	Comment	MHBE Response
	and a "new contract," ignoring the fact that, operationally, some carriers may keep the remaining family members under the same contract, rather than issuing a "new contract" to the remaining family members. We assume that you intend to require the primary enrollee's contributions to the deductible and out-of-pocket maximum be applied to the remaining family members' coverage, even if a "new contract" is not issued. This should all be clarified.	
Carefirst	**14.35.15.05(M)** requires carriers to direct on-Exchange applicants to the Exchange if the applicant directly contacts the carrier. Although currently all Exchange enrollment is through the Exchange, discussions have occurred that recognize the potential need or desire to allow for on-Exchange enrollment through a carrier. This regulation forecloses that discussion. If the Exchange wishes to maintain that option, the regulation should be modified to reflect that direct carrier enrollment is not possible only at this time.	If direct on-Exchange enrollment is permitted through the carrier at a later time, this regulation will be modified to incorporate the change in this requirement.
Carefirst	**14.35.15.05(O)** requires carriers to provide a member level report to the Exchange at least monthly. It is not clear why this information is needed by the Exchange. CareFirst recommends that the report requirement be discussed at the Plan Management Standing Committee.	The PMSC has previously discussed this requirement and carriers are currently meeting this standard.
MIA	**14.35.15.05(O)**, we suggest revising the text to indicate that the member level report must be provided "in a format specified by the Exchange."	Edit incorporated.
MIA	**14.35.15.05(P)(1)**, there is another reference to health "insurance" carriers, which is inappropriate for many dental plan organizations and all health maintenance organizations.	Edit incorporated.
Carefirst	**14.35.15.05(Q)** requires carriers to notify the Exchange in advance of a system or data change that may affect transmission or receipt of Exchange data. The Exchange should similarly be required to do the same in notifying carriers about any Exchange system or data change that will affect its transmission or receipt of carrier data.	MHBE will issue a policy on approach to testing but this operational detail is not appropriate for the regulation. MHBE already has dialogue in place with carriers to discuss changes.

Source	Comment	MHBE Response
Carefirst	**14.35.15.05(R)** requires a carrier to participate in the Exchange's annual business review process survey. In January 2016, CareFirst requested more information on how compliance with the Reference Annual Review process will be evaluated for the purposes of certification. The Exchange did not respond to this request. It remains unclear how participating in the survey affects certification. The Exchange should not proceed with this requirement until it clarifies the impact on carrier certification.	Completion of the Business Process Survey is the standard. The purpose of the Business Process Survey is to receive consistent feedback on how to improve engagement with issuer partners. The feedback returned to MHBE may result in improvements and efficiencies in Plan Certification and other technical processes. The content of the Business Survey has no effect on the outcome of plan certification.
MIA	**14.35.15.05(R)**, the defined term "authorized carrier" is used. However, in the other sections of Regulation .05, the more general term "carrier" is used. Was this deliberate?	Definition of carrier added to COMAR 14.35.01.02 to address a carrier that is not an authorized carrier. "Authorized" identifier added to all instances in Chapter 15 where the carrier would already be authorized by the Exchange at the time of the required action.
HEAU	**14.35.15.06(A)** - See binder payment comments above. Suggestion: A carrier may require an enrollee…. "Pay a binder payment to effectuate enrollment, other than renewal, in a qualified health plan."	Text edited to include reference to premium payment requirements under COMAR 14.35.07.11E and F for clarity.
OAG HEAU	**14.35.15.06(B)** - the HEAU would like this to be a mandatory requirement.	(B) incorporated into (A) to maintain payment requirements within COMAR 14.35.07.11.
Carefirst	**14.35.15.06(B)** appears to reflect newly published federal regulations allowing carriers to establish de minimis payment thresholds. However, the draft regulations only summarize or paraphrase portions of the new regulation. This is likely to cause unnecessary conflicting application of the federal law and significant confusion for all stakeholders. Additionally, the draft does not differentiate or acknowledge that binder payments must be 100% of the premium due to effectuate coverage.	(B) incorporated into (A) to maintain payment requirements within COMAR 14.35.07.11.
MIA	**14.35.15.06(C)(2)**, the citation for the grace period is incorrect. "§31-115(c) through (e)" should be replaced with "§15-1315(c) through (e)." Additionally, this citation refers only to the 3 month grace period for individual receiving	Edits incorporated to correct cross-reference and include general 31 day grace period under State law at Ins. Art. 15-209 for individuals not receiving APTC.

Source	Comment	MHBE Response
	advance payments of the federal premium tax credit. Did you intend to exclude the grace periods required under state law for other individuals?	
MIA	**14.35.15.06(D)**, the text appears too vague to clearly establish what we believe to be the intent. It seems the defined term "binder payment" could be substituted for "payment made to effectuate new coverage." It also seems preferable to replace "against outstanding balances" with "to pay outstanding balances."	Cross-reference to COMAR 14.35.07.11E used to address what coverage this rule pertains to instead of using the word "new". Suggested edit incorporated amended text from "against" to "to pay".
Carefirst	**COMAR 14.35.15.06(D)** does not provide a definition of "new enrollment". Additionally, this provision shortly summarizes complex Federal Exchange guidance, which may cause later confusion.	Cross-reference to COMAR 14.35.07.11E(1) clarifies when this rule applies instead of the word "new".
Carefirst	**14.35.15.06(E)** appears to provide for a pro rata premium payment that carriers will accept for on-exchange enrollees. All premiums that have been filed with and approved by the MIA are monthly premiums. Accordingly, CareFirst cannot bill or accept less than a monthly premium for a member to receive coverage in that month. 06(E) should be removed, or modified following MIA input and guidance.	It is MHBE's understanding that in cases of death and births that on-Exchange carriers already calculate pro-rata premiums/refunds using this calculation once the carrier has processed the file sent by MHBE.
MIA	It is unclear if **COMAR 14.35.15.06(E)** is intended to apply to the SHOP Exchange in addition to the Individual Exchange. This should be clarified, as explained previously. However, please be aware that establishing a requirement in the SHOP Exchange for all carriers to calculate premiums for a partial month on a daily pro rata basis may conflict with the business practices of many of the carriers. For ease of administration, group contracts frequently indicate that premium will always be charged for a full month. Typically, a full month's premium is required for employees who enroll prior to the 15th of the month or who disenroll after the 15th of the month. Conversely, no premium is charged for employees who enroll after the 15th of the month or who disenroll prior to the 15th of the month. The Administration often reviews and approves group contracts with language describing this type of premium	Edit made to regulation title to specify that section applies to Individual Exchange only. SHOP Exchange premium requirements will be addressed in a separate chapter at a later date.

Source	Comment	MHBE Response
	calculation for partial months of coverage. We are not sure if this practice is as prevalent in the small employer market as it is in the large group market, but it should be considered.	
HEAU	**14.35.15.06(G)** - Need to include grace period for non-APTC enrollees	Edit incorporated.
Carefirst	**14.35.15.06(G)** requires carriers to publish a standard policy for termination. It is not clear what this regulation would require. Would carriers be required to post this information on its website? The regulation should be clarified.	Edits incorporated to reflect that information should be included in billing notice, on enrollee website and available upon request.
MIA	In **COMAR 14.35.15.06(G)(1)**, the cite for the grace period is incorrect again. "§31-115(c) through (e)" should be replaced with "§15-1315(c) through (e)." Additionally, we question again whether you intended to exclude the grace periods required under state law for individuals other than those receiving advance payments of the premium tax credit?	Edits incorporated.
MIA	In **COMAR 14.35.15.06(G)(3)**, there is a reference to a payment shortfall being considered "de minimis under §B of this regulation. §B, however, does not actually use the term "de minimis."	Removed and addressed in (A).
Carefirst	**14.35.15.07** appears to repeat governing Maryland Insurance law. However, the draft regulations only summarize or paraphrase portions of the highly complex law governing carrier notices. This is likely to cause unnecessary conflicting application of the Maryland law and significant confusion for all stakeholders.	Notice regulation removed. Items pertaining to plain language, renewals and a carrier that leaves the market moved to new Regulation .07 pertaining to consumer transparency requirements.
MIA	**14.35.15.07(B)**, it seems that "delinquent" should be defined, and the time period for providing the notice should be specified (e.g. X days after the premium is due or X days prior to terminating the coverage).	This language mirrors federal language at 45 CFR 156.270(f). Language moved to COMAR 14.35.14 pertaining to premium nonpayment.

Source	Comment	MHBE Response
HEAU	**14.35.15.07(B)** - More details needed	This language mirrors federal language at 45 CFR 156.270(f). Language moved to COMAR 14.35.14 pertaining to premium nonpayment.
MIA	**14.35.15.07(D)**, the text appears too vague. We cannot determine what particular notice requirements under state law and federal regulations you are applying to carriers wishing to participate in the Exchange.	Provision moved to Chapter 14
HEAU	**14.35.15.07(D)** - Need to include HMO's and non-profits.	Provision moved to Chapter 14
MIA	**14.35.15.08(A-B)**, there is a cross-reference to COMAR 14.35.20. Chapter 20 does not currently exist under COMAR 14.35, and we did not receive a draft version of a new Chapter 20. Is the citation correct?	Cross-reference corrected to reference 14.35.16 (plan certification).
Carefirst	**14.35.15.08(A) and (B)** require carriers to offer plans certified by the Exchange under COMAR 14.35.20. The Exchange provided carries a new plan certification subtitle, COMAR 14.35.16. What is the difference between COMAR 14.35.20 and 14.35.16?	Cross-reference corrected to reference 14.35.16 (plan certification).
MIA	**14.35.15.08(C)**, the term "metal level" is used twice, but it is not defined in Chapter 15, or in the proposed draft for the general definitions section of COMAR 14.35.01.02.	Definition incorporated into COMAR 14.35.14.02B.
MIA	**14.35.15.08(D)**, the terms "tier level" and "product type" are used, but these terms are not defined in Chapter 15, or in the proposed draft for the general definitions section of COMAR 14.35.01.02.	Deleted. Dental will be addressed in a separate chapter.
Carefirst	**14.35.15.08(C) and (E)** are redundant standards both targeted at ensuring carriers do not flood the Exchange with plan offerings. Moreover, any changes in carrier benefit design will have to be duplicated to the carrier's off-exchange plans to comply with federal law. Therefore, the regulations on meaningful	Standards were presented to carriers through the SAC and plan management stakeholder meetings. Standards have already been approved by the MHBE Board of Trustees. The four plan standard has been an Exchange standard since plan year 2014 and the meaningful difference standard will be new

Source	Comment	MHBE Response
	difference should be proposed by the MIA, not the Exchange, to ensure market-wide standards are appropriately developed.	for 2017 but mirrors the FFM approach. Dental has been removed and will be addressed in a separate dental chapter.
MIA	**14.35.15.08(E)**, the intent of the regulation is unclear. Under 45 CFR §156.298, cost sharing is listed as one of the characteristics used to identify material differences between plans. Therefore, it is unclear why COMAR 14.35.15.08(E) refers only to meaningfully different standards in 45 CFR §156.298 for "non-cost-sharing variations." If two plans have material differences in cost sharing, they are automatically considered meaningfully different under the federal regulations. However, under the proposed regulation text, it appears that even if two plans had material differences in cost sharing, they would also be required to be meaningfully different in "non-cost-sharing variations."	Amended to specify only standard variation plans subject to the standard and added definition of standard variation plan mirroring the FFM language.
Carefirst	**14.35.15.08(F)** appears to repeat governing Maryland Insurance law. However, the draft regulations only summarize or paraphrase portions of the highly complex law governing carrier notices. This is likely to cause unnecessary conflicting application of the Maryland law and significant confusion for all stakeholders.	Provision deleted as it is addressed in the Insurance Article.
MIA	It appears that **14.35.15.08(F)** should be deleted in its entirety. This section simply restates the requirements set forth in §31-115(b)(5), so it adds nothing to the statute.	Provision deleted
HEAU	**14.35.15.08(F)(3)** - As written suggests that each QHP has the same premium. Needs clarification.	"Same" added to clarify that requirement is for the same plans offered on and off exchange.
MIA	It appears that **14.35.15.09** should be deleted in its entirety. Again, this regulation simply restates the requirements set forth in §31-116(f)(3), so it	Dental will be addressed in separate chapter.

Source	Comment	MHBE Response
	adds nothing to the statute. Additionally, the Administration is the agency that would enforce the provisions under this law, rather than the Exchange.	
The League	**14.35.15.10** requires carriers to file an network access plan with the Exchange in a separate and different manner than carrier's are currently required to file with the Maryland Insurance Administration. This requirement is duplicative and unnecessary.	Provision moved to Chapter 16
MIA	It appears that **14.35.15.10** should be deleted in its entirety. The requirements in this regulation would conflict with the provisions of House Bill 1318, Acts of 2016, which have already been agreed to by the Exchange, the Administration, and numerous other interested parties.	Provision moved to Chapter 16
Carefirst	**14.35.15.10(A)** requires carriers to submit a network access plan to the Exchange using an Exchange template and simultaneously follow the MIA's network adequacy reporting requirements. It is unclear how .10 O(A) complies with the prohibition in HB 1318, which will create a new MD. CODE ANN., INS. §31-115(m) that will provide that: "any certification standards established under subsection (k) of this section related to network adequacy or network directory accuracy: (1) shall be consistent with the provisions of § 15-112 of this article; and (2) may not be implemented until January 1, 2019." It is also unclear how a carrier can comply with both reporting obligations Simultaneously. It is also unclear why the duplicative reporting obligations are necessary and not unduly burdensome on carriers.	Provision moved to Chapter 16
Carefirst	**14.35.15.10(A)(3)** should have subheaders (a), (b), (c), rather than (1), (2), (3).	Provision moved to Chapter 16
Carefirst	**14.35.15.10(A)(4)** also provides that carriers have to submit "quantitative information related to network adequacy". This requirement is vague. Leaving this to future interpretation will likely create significant problems for stakeholders if it conflicts with their other applicable regulations.	Provision moved to Chapter 16

Source	Comment	MHBE Response
Carefirst	**14.35.15.12** - (1), (2), and (3) should be renumbered as (A), (B), (C).	Edit incorporated.
Carefirst	**14.35.15.12(3)** requires carriers to submit premium rate changes to the Exchange. How is this different than the requirement in proposed 14.35.16.05(D)?	Provision moved to Chapter 16
Carefirst	**14.35.15.13** - MD. CODE, INS. §31-115(k)(l)(ii) provides that the Exchange can only take enforcement action against a plan that does not satisfy requirements or has otherwise violated standards for certification that are "not otherwise under the regulatory and enforcement authority of the Commissioner." Draft .13, however, does not clarify that Exchange cannot take enforcement action against a carrier if the MIA has regulatory and enforcement authority in that area. The section should clearly indicate that the Exchange has limited enforcement authority only to the extent the MIA does not regulate the field.	Regulation .13 removed and only addressed under plan certification (chapter 16).
Carefirst	**14.35.15.13(A)** provides that the Exchange can take action for a carrier's failure to comply with "any other federal or state laws". This provision is overly broad and violates MD. CODE, INS. §31-ll 5(k)(l)(ii).	Regulation .13 removed and only addressed under plan certification (chapter 16).
Carefirst	**14.35.15.13(B)** allows the Exchange to impose sanctions against a carrier if the MIA takes action against a carrier. This provision is overly broad and violates MD. CODE, INS. §31-l 15(k)(l)(ii).	Regulation .13 removed and only addressed under plan certification (chapter 16).