MARYLAND HEALTH BENEFIT EXCHANGE RESPONSES TO INFORMAL PUBLIC COMMENTS ON PROPOSED COMAR 14.35.07

The following charts summarize informal public comments submitted to Maryland Health Benefit Exchange (MHBE) based on two versions of proposed COMAR 14.35.07. The first chart includes comments submitted by April 27, 2016 in advance of the May 12, 2016 meeting and the second chart includes comments submitted by May 23, 2017 after the meeting. 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).

Source Key

Carefirst = CareFirst BlueCross BlueShield	**HEAU = Office of Attorney General, Health Education and Advocacy Unit**	**MIA = Maryland Insurance Administration**

Summary of Comments Received and MHBE Response to Comments

Round 1: 14.35.07 COMMENTS Submitted by April 27, 2016		
Source	**Source Comment**	**MHBE Response to Source Comment**
Carefirst, MIA, HEAU	**General Comment -** Requirements appear to repeat federal law, which may create discrepancies between the governing federal law and Exchange regulations when the federal government modifies or reinterprets the regulations in the future. The Exchange should not, and does not need to, codify federal regulations into State law for them to apply to Exchange operations. Moreover, even if the Exchange still feels it necessary to reiterate federal or State insurance law in Exchange regulation, the draft regulations do not mirror the language of existing federal or Maryland insurance law. Rather, the draft regulations only summarize or paraphrase portions	45 CFR Parts 155 and 156, among others, instruct the Exchange to make a decision based on the requirements identified within the regulation. Therefore, MHBE believes it must, under the Maryland Administrative Procedure Act, set forth regulations that alert individuals to the eligibility requirements MHBE will enforce. Please refer to the document regarding MHBE's approach to implementing federal requirements in state regulations for additional information about this approach, which may be found here: http://www.marylandhbe.com/policy-legislation/public-comment/.

Round 1: 14.35.07 COMMENTS Submitted by April 27, 2016		
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	of the highly complex applicable law. This is likely to cause unnecessary conflicting application of the governing laws and significant confusion for all stakeholders.	
Carefirst, MIA	**COMAR 14.35.07.02** (Definitions) - Recommendation that definitions either mirror the federal terms or terms used in other State laws and regulations or cite to them. Failure to make either modification, however, will likely cause unnecessary conflicting application of the governing laws and significant confusion for all stakeholders. Ensure that definitions captured within multiple chapters are reflected in COMAR 14.35.01.02.	Definitions have been cross-checked against federal definitions, the Insurance Article and State Medicaid regulations to ensure conformity across laws and rules. Definitions used across multiple chapters are included in COMAR 14.35.01.02. For example, definition of "institution" amended to incorporate existing MA definition of medical institution under 10.09.24.02.37 and public institution under 10.09.24.02.46. Clarification edits incorporated to distinguish plan variations - with cost sharing reductions and without - and metal levels in COMAR 14.35.01.02.
Chris Keen	**14.35.07.02(B)(4)** (Definition of CSR Plan for 101-150% FPL) **-** CSR amount should be 87% not 84%.	Edit incorporated.
MIA	**14.35.07.03(C)** (Information requirements for application) **-** Intent of income tax form filing requirement unclear as to 1) whether requirement is for filing at family or couple, 2) where there is an exception permitted and 3) if rule applies to Medicaid.	Clarification edits incorporated in (4) to align with 45 CFR 155.310(k)(3) and in (5) to specify that the tax filing requirement is specific to APTC/CSR not MA/MCHP under the definition of tax filer (45 CFR 155.300 and 14.35.02.16).
MIA	**14.35.07.03(D)(1)** (Information required of non-applicants) - Lead in confusing	Clarification edits incorporated to (C) and the definition of non-applicant under .02B(13).
Carefirst	**COMAR 14.35.07.03(E)** (Timing of eligibility determination) - Rule provides that individual may seek an eligibility determination at any time during the year. This may be true for Medicaid, but how does this align with enrollment periods?	An individual may submit an application and receive an eligibility determination at any time under 45 CFR 155.310(c). The individual, if otherwise eligible under .04, may only enroll if they are eligible for an SEP outside of the annual open enrollment. Clarification edits added.
MIA	**14.35.07.03(E) -** Add definition for "eligibility determination".	Definition added to 14.35.02.01.

Round 1: 14.35.07 COMMENTS Submitted by April 27, 2016		
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Carefirst	**COMAR 14.35.07.03(F)** (Incomplete application) - This provision should be clarified to state that the coverage effective date will be the first day of the month after the *complete* application has been processed, unless the individual is otherwise eligible for a retroactive effective date based on an SEP.	An individual may submit an application and receive an eligibility determination at any time under 45 CFR 155.310(c). The individual, if otherwise eligible under .04, may only enroll under the effective dates specified in .11.
MIA	**14.35.07.04(A) -** Remove reference to COMAR 14.35.11.04 which deals with notifications of right to request a fair hearing.	Clarification edit incorporated to specify that the notice will include notice of the right to request a fair hearing.
Carefirst	**COMAR 14.35.07.04(A)(1)** (QHP eligibility requirements) - Clarification required to clearly define the eligibility requirements.	Edits incorporated to clarify the three unique requirements (citizen/lawfully present, resident, not incarcerated).
Carefirst	**COMAR 14.35.07.04(B)-(C)** (Employer notification) - The proposed notice does not indicate if the Exchange has independently verified the employee's attestation that they were neither enrolled in employer-sponsored coverage nor eligible for affordable, minimum-value employer-sponsored coverage. Additionally, the Exchange has not to date provided any identifying information (such as SSN) to the employer to be able to defend any such notice. The regulations should require the Exchange to identify the employee by name, DOB and SSN so that the employer can determine if the individual is even an employee of the employer. Finally, the notices should have to be sent to the employer's legal address or to its resident agent as identified with the Maryland Department of Assessments & Taxation.	The proposed text follows 45 CFR 155.310(h) as amended in 81 FR 12341 (the HHS requirement on notification of employers). MHBE shall follow the verification requirements at 45 CFR 155.320(b) and will include these requirements in proposed regulations at a later date. Based on the request of employers and other stakeholders, the Exchange will include the same information that the FFM has indicated that it will provide in this notice, which includes: the employee's name, DOB, last four digits of SSN if available and Exchange ID. The Exchange uses the employer information provided by the employee for the employer's address and is not required to provide information to a legal address.
MIA, Carefirst	**14.35.07.04(C)** (Service area) **-** "Service area" should be defined. Clarification required to address whether rule applies to SHOP.	"Service area" under .04(A) is addressed in .07F. References to the Individual Exchange added to the chapter title and scope for clarification. The SHOP Exchange will be addressed in a different chapter.
Carefirst	**COMAR 14.35.07.04(D)** (Incomplete application) - Does not specify if notice sent to applicant and Exchange pends the application or if	MHBE may not provide an eligibility determination for an incomplete application under 45 CFR 155.310(k). An individual will not be able to submit an incomplete application online and will not able to plan shop if

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	the Exchange forwards the application to the carrier as an active enrollment as a self-attestation.	an incomplete application is provided by mail. Therefore, the carrier will not receive an enrollment based on an incomplete application. Edits incorporated to clarify this requirement.
MIA, Carefirst	**14.35.07.04(F)** (Electronic notice election) **-** Clarification required for who can elect to receive notice electronically (Who is the applicant?) and how the individual confirms the election by mail.	Definition of applicant added to include individuals only, not the employer as the employer does not provide information to the Exchange. Edit incorporated to clarify that the mailed notice is confirmation of the consumer's election to receive notices electronically and requires no further action by the individual (see 45 CFR 155.230(d)(1) and 42 CFR 435.918).
Carefirst	**COMAR 14.35.07.06(A)(2)(b)** (Minor residency) - References the parent or "caretaker" with whom the individual resides. It is unclear if "caretaker" is intended to mean a "caretaker relative" as that term is used to determine medical assistance eligibility (e.g., see MD. CODE REGS. 10.09.24.02), or if "caretaker" could be construed more broadly here. For consistency, CareFirst recommends the Exchange apply the existing "caretaker relative" definition.	Mirrors 45 CFR 155.305(a)(3)(ii)(B). Included internal cross-references to (A) for additional clarification.
MIA	**14.35.07.06(D)** (Exchange service areas) **-** Under what circumstances would there be more than one Exchange in Maryland?	The area may be larger, for instance if Maryland participated in a multi-state Exchange.
Carefirst	**COMAR 14.35.07.06(E)** (Residency requirement) **-** Should define "temporary absence" to include a more definitive timeframe.	Mirrors 45 CFR 155.305(a)(3)(v). State case law is available on residency requirements for other programs.
Carefirst	**COMAR 14.35.07.07(B)** (APTC/CSR eligibility) - Does not include that individual isn't eligible for APTC/CSR if in catastrophic plan. A qualified individual or dependent who is enrolled in an employer-sponsored plan that does not meet minimum essential coverage requirements is *not* required to terminate that plan in order to become eligible for APTC.	MEC is defined in 14.35.01.02 as the IRS MEC definition at 26 USC 5000(f) and 26 CFR 1.5000A-2(c), which includes "Coverage under a health plan offered in the individual market within a State". (B) pertaining to ESI is specifically included to clarify that enrollment in an employer plan that is not affordable or meet the MV requirements is still considered MEC for purposes of APTC/CSR eligibility alone (26 CFR 1.36B-2(c)(3)(vii)(A).

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Carefirst	**COMAR 14.35.07.07(J)** (APTC effective date for changes in household) - Appears to be misplaced in this section, as do (4) and (5). This section also does not address all qualifying event SEP effective dates.	Provisions included in this regulation because they pertain to an individual's eligibility for APTC. Rule added to capture non-SEP effective dates as well.
Carefirst	**COMAR 14.35.07.07(J)** (Enrollment dates) - Does not clearly define the effective dates as it provides that the date is (1) and (2) or (3), (4), or (5).	Edits incorporated to remove incorrect use of and/or.
MIA	**14.35.07.10** (Enrollment dates) **-** Enrollment dates only pertain to Individual Exchange not SHOP.	Edits incorporated in title and scope to specify that Chapter 7 only refers to the Individual Exchange. A separate chapter will address SHOP eligibility, including SEPs.
Carefirst, HEAU	**14.35.07.10(A)** (Enrollment transaction) - provides that a qualified individual may enroll in a QHP, APTC, cost sharing reductions or catastrophic plan. This language is confusing as APTC is neither a QHP nor catastrophic plan but rather a means for paying for a QHP.	Edits incorporated to clarify enrollment in a QHP, insurance affordability program except for Medicaid (which includes a QHP with APTC/CSR), or catastrophic coverage.
Carefirst, MIA	**14.35.07.10(D)** (Enrollment transaction steps) - Clarification needed for requirement steps.	Edits for clarification incorporated.
Carefirst	**14.35.07.10(D)(3)(a)** (Enrollment transaction steps) - The Exchange does not notify carriers but rather transmits information to a carrier through an 834. This language should be modified to more precisely reflect the operational requirements of enrollment.	Edits for clarification incorporated, specified "notify" changed to "transmit...to the carrier". Additional transmittal requirements, such as the 834 process, is captured in MHBE-carrier operational instructions and are not appropriate for a regulation.
HEAU, Carefirst	**14.35.07.10(D)(3)(b)** (Timing of Exchange providing information to carrier) **-** Set Exchange time standard (Carefirst). Add "Promptly and without undue delay" per federal regulations (HEAU).	Edit incorporated to mirror federal language under 45 CFR 155.400(b)(1).
Carefirst	**14.35.07.10(D)(3)(b)(ii)** (Cost-sharing reduction plan variation) - Provides that the Exchange will identify an applicant's "cost-share	Edits incorporated clarifying that the QHP may include a CSR variation of the plan (CSR plans are defined in .02B(3)-(5) and additional definitions of

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	reduction eligibility category". There are no categories of cost-share reductions. This language needs to be modified to be more precise.	cost-sharing reduction and metal level plan variations added to COMAR 14.35.01.02).
Carefirst	**14.35.07.10(E)** (Premium payment) - States that an individual must only make a binder payment to effectuate coverage when the individual has elected a new plan after a break in coverage AND the individual has enrollment for the first time in a plan in the Exchange. The "and" should be an "or".	Edit incorporated.
Carefirst	**14.35.07.10(E)** (Premium payment)- Do not provide that an individual must also pay a binder payment if the individual selects a new plan with a different legal entity of the same carrier.	Edit incorporated in new proposed .11E(2) as: *A new QHP or catastrophic plan includes a QHP or catastrophic plan offered by a different carrier of the same holding company.*
Carefirst	**14.35.07.10(E)** - Finally, the requirements to accept a binder payment are identified in federal regulation. The draft regulations, however, do not mirror the language of existing federal law but only summarize or paraphrase it. This is likely to cause unnecessary conflicting application of the governing laws and significant confusion for all stakeholders. See 45 CFR §155.400.	45 CFR 155.400(e) pertaining to binder payments allows the Exchange to set a policy about binder payments but does not specify provisions that must be followed by SBMs, only the FFM. Based on stakeholder and consumer feedback, MHBE has incorporated the FFM deadlines for premium payments into this version of the chapter at .10E. Additionally, MHBE has proposed a uniform date for payments starting in 2018 to reduce consumer confusion, particularly in instances of retroactive coverage where multiple months may be due, and streamline the standard across the Exchange.
Carefirst	**14.35.07.10(F)** requires the Exchange to maintain records of all enrollments through the Exchange, but does not make clear if this includes reinstatements.	MHBE must maintain records of all enrollments in QHP issuers through the Exchange under 45 CFR 155.400(c). “All enrollments” in (F) includes reinstatements. If the carrier has previously sent MHBE a termination 834 due to non-payment and then determines the consumer is eligible for reinstatement, the carrier would require an add 834 from MHBE. The carrier must notify MHBE of the respective QHP households that are eligible for reinstatement. This information is included in the operational guides provided to carriers.

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MIA	**14.35.07.11(A)(1)** (Loss of MEC SEP)**-** This item is incomplete because it does not include an option for an SEP if an individual loses individual health insurance coverage. The current item is limited solely to the loss of employer-sponsored coverage.	An individual plan that ends (even if renewable) is included in .11B(4).
MIA	**14.35.07.11(A)(2)** refers to COBRA continuation coverage. Consider expanding this to include continuation coverage under State law.	Suggestion incorporated.
HEAU	**14.35.07.11(B)(2)** (Loss of MEC doesn't apply to individuals terminated for ineligibility due to citizenship/lawful presence verification issue) **-** Where is requirement located in federal law?	An individual who is terminated for failure to to meet the eligibility requirements under .04A(1) and 45 CFR 155.315(f) is not eligible for an SEP unless the individual qualifies for another SEP such as change in lawful presence status. MHBE believes this requirement is implied in the eligibility requirements but has specified this provision based on CMS guidance about SEP documentation and enforcement (https://blog.cms.gov/2016/01/19/clarifying-eliminating-and-enforcing-special-enrollment-periods/).
MIA	**14.35.07.11(C)** (Loss of MEC SEP)**-** Trigger event defined as "loses eligibility for minimum essential coverage" under the previous plan. However, for the situation described in §A(3) (coverage under a non-calendar year plan), the date should be defined as the end of the policy or plan year because it includes an off-Exchange plan even if the individual can renew. Refer to 45 CFR §155.420(d)(1)(ii).	Example about non-calendar year plans is incorporated in .12A(4). Clarification edit incorporated to explain that "the policy or plan year ends in the middle of the calendar year."
MIA	**14.35.07.11(E)(1) and (2)** (Loss of MEC SEP) **-** Effective dates must be consistent with 45 CFR §155.420(b)(2)(iv). If the plan selection is made after the date of the triggering event, the federal regulations specify that the effective date is not until the first day of the second following month, if the plan selection is received between the 16th and the last day of any month.	.12E(1) mirrors the federal requirement of an effective date on the 1st of the month after the loss of MEC or the coverage ends if the plan selection is made before the loss or the coverage ends (45 CFR 155.420(b)(2)(iv)). In addition, MHBE proposes to allow for an effective date of the 1st of the month after the plan selection if the selection is made after the loss of MEC or the coverage ends as permitted in 45 CFR 155.420(b)(2)(iv) as well. This follows current Exchange operational rules as well.

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MIA, HEAU	**14.35.07.11(F)** (Loss of MEC SEP - one time during calendar year for medically needy) **-** We believe §F was intended to refer to the special enrollment period for loss of medically needy coverage, as described in §A(5) of the regulation.	Edit incorporated, rule aligns to medically needy SEP now.
MIA	**14.35.07.12(E)(1)** (SEP for marriage and divorce) **-** Is "formation of civil partnerships" to be included as SEP? Also, under 45 CFR §155.420(b), the effective date for the special enrollment period due to divorce is governed by the standard effective date provision under 45 CFR §155.420 (b)(1), rather than the special effective date provision under 45 CFR §155.420(b)(2)(ii).	Civil partnerships removed based on definition of marriage from CMS/IRS: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/marketplace-guidance-on-irs-2013-17.pdf and https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/frequently-asked-questions-on-coverage-of-same-sex-spouses.pdf. .13(E)(4) added to include effective dates under (b)(1) for divorce.
HEAU	**14.35.07.13(A)(2)** (SEP for misconduct of non-Exchange entity) **-** Add definition of "misconduct" and federal language on NEE.	"Misconduct" and non-Exchange entity reference added to .14 and 45 CFR 155.420(d)(4) definition of misconduct added to .14(B).
MIA, HEAU, Carefirst	**14.35.07.13-.15** (Notification length and avenues for individual to alert exchange of error) - Provide for additional notification length. How will length be calculated? Where can notice be provided? The 2017 Notice of Benefit and Payment Parameters at 155.430(b)(1)(iv) allows 60 days after discovery. Maryland should provide at least 60 days. notification to the Exchange should mean the Exchange or any of its agents (navigators, DSS, brokers, etc.). Ten days is an unfair time limitation.	Time amended to allow for: 1) notification of 30 days and 2) SEP of 30 days for a total of 60 days. Notification to a consumer assistance worker of the Exchange - navigator, authorized broker or call center representative - added. Notification modes to the Exchange that mirror application avenues (ie mail, phone, online) added as well. As the Exchange determines SEP eligibility, an individual must notify the Exchange of the request for an SEP. However, a previous action by MIA may be the basis for an SEP. *In second round of comments amended to allow for 60 days for 2017 to mirror current forms submitted to MIA and 30 days for 2018.* Retro termination amendment added to proposed COMAR 14.35.14(45 CFR 155.430(b) amendments are to terminations not SEPs).

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HEAU, Carefirst	**14.35.07.13-.15** (Effective date) **-** Could include retrospective and prospective (HEAU). The regulation does not provide that the Exchange has any responsibility to inform a member retroactively enrolled that they are responsible for all premiums past and present before being effectuated. This lack of Exchange responsibility is likely to cause significant consumer confusion. (Carefirst)	Prospective added to rule to clarify that date may be retrospective or prospective depending on the circumstances. Exchange consumer assistance workers are already trained to assist the individual in making decisions about their eligibility and enrollment options. MHBE proposes to amend Navigator training standards under COMAR 14.35.02 to cover the additional information suggested in this comment.
MIA	**14.35.07.14(A)** (SEP that may involve MIA) - Explain what "collaboration and coordination" means in further detail. In a Complaint investigation, the Administration may issue an order finding a violation, may find no violation and allow the complainant the right to a hearing, or may close the case without a finding because the carrier has changed its position. If an order is issued, the carrier has the right to request a hearing. Does the Exchange anticipate conducting an additional investigation, or being notified of the Administration's investigation? Has the Exchange contemplated whether an order would need to be issued by the Administration to allow the SEP?	"Collaboration and coordination" is intended to encompass any process that MIA or the Exchange believes is required to investigate and make a decision regarding a case. The Exchange may be able to determine eligibility for an SEP even if the MIA must take additional investigation, hearing or other steps to fully address a case under MIA's duties. For example, if an investigation reveals that a broker provided fraudulent information to an individual that prevented the individual from enrolling in a QHP, the Exchange may have enough information to determine the individual's SEP eligibility. However, the MIA may need to take further steps to address ramifications of this action on the broker's license (and the Exchange separately may take steps to address ramifications of this action on the broker's Exchange certification).
MIA	**14.35.07.14(B)** (Notification length to MIA) - There are no statutory limits on when a person may file a complaint against a producer. The Administration may issue an order against a producer, but it is likely to take some time for the investigation to be completed.	The Exchange may be able to determine eligibility for an SEP even if the MIA must take additional investigation, hearing or other steps to fully address a case under MIA's duties. For example, if an investigation reveals that a broker provided fraudulent information to an individual that prevented the individual from enrolling in a QHP, the Exchange may have enough information to determine the individual's SEP eligibility. However, the MIA may need to take further steps to address ramifications of this action on the broker's license (and the Exchange separately may take steps to address ramifications of this action on the broker's Exchange certification).

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Source	**Source Comment**	**MHBE Response to Source Comment**
HEAU	**14.35.07.15** (Exchange determination of exceptional circ. SEP) - "In its sole discretion" suggests that consumers have no appeal rights.	Edits incorporated to delete "sole discretion". Determinations by MHBE for SEP eligibility may be appealed.
MIA	**14.35.07.16(D)** (Move SEP) - Under 45 CFR §155.420 (b)(2)(iv), the calculation of the effective date is the same for triggering events that occur prior to January 1, 2017, and those that occur on or after that date. The proposed regulation should track the language of the federal regulation.	After 1/1/17, or earlier at the Exchange's option (which MHBE has not proposed), an individual must be allowed to select a plan up to 60 days prior to the move under 45 CFR 155.420(c)(2). MHBE has not elected this option and therefore the only effective date available prior to 1/1/17 under 45 CFR 155.420(b)(2)(iv) is to follow the 15th day of the month rule. However, the (b)(2)(iv) does not address effective dates for selections made on the date of the move if the Exchange does not select the 60 day before option prior to 1/1/17 under 45 CFR 155.420(c)(2). MHBE believes that the effective date on the 1st of the month does not apply until 1/1/17.

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
Carefirst	From Reg .02 Delete "*Catastrophic Plan".* Catastrophic plan is already defined in 14.35.01.02 and so does not need to be defined here.	Edit incorporated.
Carefirst	*(4) "CSR plan for 151-200 percent FPL" means a QHP with an actuarial value of 87 percent* ***plus or minus the de minimis variation for a silver plan variation*** **[BML1]** ***that is available to an individual who is expected to have a household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL for the benefit year for which coverage is requested****.* [BML2] Add the bolded/underlined words above [BML1]See 45 CFR §156.420(a)(2)(ii).	"De minimis variation" language incorporated. Suggestion regarding eligibility (ie "that is available to an individual….") is addressed in 14.35.07.09. MHBE believes that the eligibility for the type of plan does not need to be duplicated in both the definition and the eligibility regulation.

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
	[BML2]See 45 CFR § 155.305(g)(2)(ii).	
Carefirst	*(6) "CSR plan for 201-250 percent FPL" means a QHP with an actuarial value of 73 percent plus or minus the de minimis variation for a silver plan variation* [BML1] *that is available to an individual who is expected to have a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL for the benefit year for which coverage is requested.* [BML2] Add the bolded/underlined words above [BML1]See 45 CFR § 156.420(a)(3)(ii). [BML2]See 45 CFR § 155.305(g)(2)(iii).	
Carefirst	Delete: *"Employer group health insurance coverage."* It is not used in chapter .07. If the term needs to be used in a different chapter, CareFirst recommends it be added to chapter .01 or to that chapter.	Definition term amended to "employer-sponsored coverage" which is used in 14.35.07.12A(2).
Carefirst	Delete: "*Federal Poverty Level"*	Edit not incorporated; term is used within Chapter 7.
Carefirst	Delete: "Qualifying eligible employer-sponsored plan" CareFirst has struck this definition as it has struck language below in Chapter 7 where the only other 2 places the definition is used.	Edit not incorporated; term is used in 14.35.07.12A(2).
Carefirst	***.03 Applying for Coverage.*** *A. Individuals may apply to enroll in a QHP or an insurance affordability program through the Exchange using the single, streamlined application form approved by the Exchange.* *B. Individuals may submit the application:* *(1) By telephone;* *(2) On the Exchange's internet website;* *(3) Using in-person assistance, including with provision of reasonable accommodations; or* *(4) By mail.* [BML1]	Chapter 7 updated to reflect that all references to Exchange are to the Individual Exchange. SHOP will be addressed in a subsequent chapter.

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	[BML1] Is this true for both the Individual Exchange and the SHOP Exchange? If not, .03(A) should be clarified to provide that this regulation only applies to the Individual Exchange.	
Carefirst	*(6) If the applicant is applying for enrollment in an insurance affordability program under Regulation .02B(11)(c) or .02B(11)(d) of this chapter* ***and the applicant files his or her income tax return as a married couple****, an attestation that the applicant intends to file a joint income tax return for the benefit year in which the individual is seeking coverage, except:* _____ Add the bolded/underlined words above	Edit incorporated.
Carefirst	*(6)(b) If the individual in a married couple qualifies to file as head of household; and [BML1]* *[BML1] CareFirst does not understand what the affirmative obligation in the attestation is for this exception. See also MIA 4/8/16 comments II(9).*	Edit incorporated to address that the attestation is that the applicant intends to file as a married couple.
Carefirst	*(7) The applicant's signature, including either an electronic or telephonic signature* [BML1] *, under penalties of perjury.* [BML1] What is a telephonic signature?	Verbal - it will be recorded when an application is taken over the phone by a call center representative. The federal term used.
Carefirst	*D. Non-Applicant.(1) A non-applicant* ***who applies for insurance affordability programs on behalf of a member in the non-applicant's tax filing household shall*** *provide the following information on the application:* _____ Add the bolded/underlined words above	Edit incorporated.

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
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Carefirst	*G. In an individual submits an incomplete application, the Exchange shall promptly send the individual a notice described in .04(D) of this chapter informing the individual that the application is incomplete. The individual shall have 90 days to complete the application and receive an eligibility determination from date the notice is sent.* It remains unclear if the applicant is enrolled at this point or if their application is pended. MHBE needs to clearly identify the implications of an incomplete application here so that consumers and carriers are uniformly aware of what happens.	The applicant is not enrolled at this point. The Exchange may not provide an eligibility determination for an incomplete application. Because the online application does not allow for submission when required sections are incomplete, this situation would only arise for the submission of paper applications. However, a worker may also not process a paper application in the online system without all information either. This provision does not refer to the inconsistency process under 45 CFR 155.315(f) which will be addressed in a subsequent regulation chapter.
Carefirst	.04A *The Exchange shall provide timely written notice to an applicant of any eligibility determination made under this chapter in accordance with 45 CFR §§ 155.310 and 155.515.* See MIA 4/8/16 comment II(14).	Reference to 45 CFR §155.310(g) incorporated; however, MHBE believes that the reference to the notice of appeals rights should remain.
Carefirst	.04C, *(4) Notify the employer of the employer's right to appeal the determination to HHS;* ***and (5) Be sent to the employer's resident agent identified by the Maryland Department of Assessments & Taxation.*** _____ Add the bolded/underlined words above	Edit not incorporated at this time. The Exchange is only required to send notices to the employer's address provided by the enrollee. This mirrors the FFM's process as well. Additionally, MHBE does not currently have an automated process or resources available to identify the employer's RA address. While this information may be readily discernable for certain employers listed in an employee's application, this process will not reduce all errors as employees may indicate the incorporate legal employer as well. MHBE plans to further discuss this proposal with stakeholders and consider it for the future.
Carefirst	.04D . *(4) Specify that the applicant shall have 90 days to provide the missing documentation to the Exchange beginning on the* ***submitted application; and***	Edit not incorporated. The applicant is not enrolled at this point. The Exchange may not provide an eligibility determination for an incomplete application. Because the online application does not allow for submission when required sections are incomplete, this situation would only

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
	(5) Indicate that the individual may lose coverage through the Exchange if they fail to timely provide the requested verification documentation. _____ Add the bolded/underlined words above	arise for the submission of paper applications. However, a worker may also not process a paper application in the online system without all information either. This provision does not refer to the inconsistency process under 45 CFR 155.315(f) which will be addressed in a subsequent regulation chapter.
Carefirst	Regulation .06. CareFirst recommends that these 4 pages of regulations be deleted, as they are merely duplicative of governing federal law. MHBE can instead cite to Section 1411(b)(2) of the Affordable Care Act.	Edit not incorporated. MHBE has listed all applicable citizenship, US national and lawfully present statuses eligible for QHP enrollment. MHBE has combined this list from the multiple cross-references contained with Section 1411(b)(2) of the Affordable Care Act and corresponding federal regulations. This approach mirrors Medicaid's approach in state regulations. MHBE receives many questions about who meets these statuses and believes this approach will assist with these questions in the future.
Carefirst	*.0~~6~~7 General Eligibility Requirements – Residency in ~~Exchange Service Area~~ the State of Maryland.*Here, again, CareFirst recommends just citing to 45 CFR § 155.305.	Edit not incorporated. PRovision is structured to allow for only changing .07F if the Exchange's service area would be amended - such as for a multi-state exchange - in the future.
Carefirst	Regulation .0~~6~~7*D. If both spouses in a tax household enroll in a QHP through the Exchange, a tax dependent may only enroll in a QHP through the Exchange, or through* ***a different health benefit exchange for which the dependent*** *meets the residency standard* _____ Add the bolded/underlined words above	Amended to: *If both spouses in a tax household enroll in a QHP through the Individual Exchange, a tax dependent may only enroll in a QHP through the Individual Exchange, or through a different health benefit exchange for which the dependent meets the residency standard.*
Carefirst	Regulation .0~~6~~7E. *The Exchange may not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the residency standard but for a temporary absence from the ~~service area of the Exchange~~ State of Maryland for less than 60 days* [BML1] ~~*and intends to return when the purpose of the absence has been accomplished*~~	60 day edit not incorporated as this is not encompassed in CMS' guidance on residency:

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
	[BML1]The MHBE should define what a "temporary absence" means so that it can be applied consistently and uniformly. See most recent CMS SEP requirements for permanent moves.	
HEAU	In order to provide appropriate notice to consumers and provide a regulatory basis for consumers to contest failures to effectuate their coverage for non-payment when they do not have adequate notice, the HEAU also requests the following addition to 14.35.07.04: *If an applicant enrolls in a new QHP or catastrophic plan under, the Exchange shall notify the applicant of the date the applicant's first premium payment is due to the QHP or catastrophic carrier and shall notify the applicant that failure to pay the first premium payment for the new plan will result in a failure to enroll, may result in a tax penalty for failing to have minimum essential coverage, and may prevent the applicant from the ability to enroll again until the next open enrollment period, unless he otherwise qualifies for a special enrollment period.*	MHBE has set forth standard 1st month's due dates starting in 2018 to provide consumers adequate notice about the premium due date.
Carefirst	Regulation .0~~7~~8 A *A tax filer shall be determined eligible for APTC credit* ***in accordance with 26 CFR § 1.36B, 45 CFR § 155.340 and 45 CFR Part 56, Subpart E*** _____ Add the bolded/underlined words above	Edit not incorporated. 45 CFR Parts 155 and 156, among others, instruct the Exchange to make a decision based on the requirements identified within the regulation. Therefore, MHBE believes it must, under the Maryland Administrative Procedure Act, set forth regulations that alert individuals to the eligibility requirements MHBE will enforce. Please refer to the document regarding MHBE's approach to implementing federal requirements in state regulations for additional information about this approach, which may be found here:

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
		http://www.marylandhbe.com/policy-legislation/public-comment/.
Carefirst	Regulation .0~~78~~ A(1)-(2) Regulation .0~~78~~ B Regulation .0~~78~~ C _____ Delete	Edit not incorporated. 45 CFR Parts 155 and 156, among others, instruct the Exchange to make a decision based on the requirements identified within the regulation. Therefore, MHBE believes it must, under the Maryland Administrative Procedure Act, set forth regulations that alert individuals to the eligibility requirements MHBE will enforce. Please refer to the document regarding MHBE's approach to implementing federal requirements in state regulations for additional information about this approach, which may be found here: http://www.marylandhbe.com/policy-legislation/public-comment/.
Carefirst	Regulation .0~~78~~ D. *A tax filer may only receive advance payments of the premium tax credit on behalf of an applicant who is enrolled in a QHP through the Exchange.*[BML1] [BML1] Delete. This is overly broad, as there has to be certain relationships between the applicant and the tax filer to make this applicable.	Amended to: *A tax filer may only receive APTC on behalf of a tax filer only if one or more applicants for whom the tax filer attests that the tax filer expects to claim a personal exemption deduction for the benefit year, including the tax filer and the tax filer's spouse, is enrolled in a QHP that is not a catastrophic plan, through the Individual Exchange.*
Carefirst	Regulation .0~~78~~ E - Delete. We believe this is all covered by applicable federal regulations. If the MHBE has a specific allocation of APTC, please clarify what that allocation is.	Edit not incorporated. 45 CFR Parts 155 and 156, among others, instruct the Exchange to make a decision based on the requirements identified within the regulation. Therefore, MHBE believes it must, under the Maryland Administrative Procedure Act, set forth regulations that alert individuals to the eligibility requirements MHBE will enforce. Please refer to the document regarding MHBE's approach to implementing federal requirements in state regulations for additional information about this approach, which may be found here:
Carefirst	Regulation .0~~78~~ J,K,L- Delete	
Carefirst	Regulation .0~~89~~ A. *A. An applicant shall be determined eligible for cost-sharing reductions* ***in accordance with 45 CFR Part 56, Subpart E****.* Add the bolded/underlined words above. Delete the Remainder of A, as well as B-F	

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
Carefirst	Regulation .0910 A *A. An applicant shall be determined eligible for enrollment through the* ***Individual*** *Exchange in a catastrophic plan if the applicant has met the requirements for eligibility for enrollment in a QHP through the* ***Individual*** *Exchange under Regulation .05 of this chapter* ***and the requirements of Section 1302(e) of the Affordable Care Act.*** Add the bolded/underlined words above. Delete the Remainder of A	http://www.marylandhbe.com/policy-legislation/public-comment/.
Carefirst	*.10B HHS shall establish the annual open enrollment period - See MIA 4/8/16 comments II(25).*	As the Insurance Article only refers to the CMS provision on enrollment periods, MHBE believes that it should provide this information within the regulation to provide appropriate public notice.
Carefirst	*.10C.* Revise text as suggested (remove dates and say in compliance with CFR and HHS guidance) CareFirst notes that putting these dates into State law will unnecessarily bind the Exchange in the future to these dates and limit future flexibility.	MHBE has allowed for such changes at 14.35.07.11C(3).
Carefirst	*.10E (1)* - add the following: or (c) *The individual has elected a new product from the same carrier*	Edit incorporated.
HEAU	14.35.07.10(E)(3-9) – Payment of the First Month's Premium. The HEAU appreciates the value in having clear, articulable premium due dates for the initial premium payment. Unfortunately, because MHBE cannot provide the consumer with the exact premium amount due, it is unfair to the consumer to require him to provide payment, by a date certain, when the consumer may not yet even know what the amount due is. The HEAU suggests the following addition to (3)(addition in italics): The first month's premium payment to effectuate prospective coverage for plan selections made during an annual open enrollment period or during a special enrollment period described in…shall be due on a date specified by the authorized carrier of the QHP and uniformly	Until 2018: This language mirrors the FFM language at 45 CFR 155.400(e) and MHBE does not accept the comment as this language already provides a broad range of time to pay the premium. 2018 and after: MHBE believes that specifying a uniform due date across carriers is the best approach to balancing 1) the importance of setting a uniform date that can be used by MHBE for consumer messaging and will not be confusing to consumer's who switch plans between years or in an SEP and 2) the operational impact to carriers. If MHBE were to set a

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
	applied that is no earlier than the coverage effective date and no later than 30 calendar days from the coverage effective date *or 15 calendar days from the date of invoice, whichever is later*. The same addition should be made to sections (4)-(9).	moving date - ie 15 calendar days after the date of the invoice - carriers would be challenged to record and act on dates that would vary by consumer and consumers would be required to calculate their own due date.
Carefirst	*.10E (4-6)* - Delete. This limits carriers' ability to implement internal business processes and procedures that affect their fiscal sustainability.	Because carriers may set different due dates and only the carrier provides information about the final billing amount and due date, consumers are often confused about when their payment is due. As such, MHBE sees significant volumes of consumers who fail to pay on time because of confusion about the due date, particularly for SEPs. As such, MHBE believes that it is important to set a uniform Exchange due to date to provide notice to consumers. Further, MHBE has allowed for a delayed implementation of the specified date until 2018 to allow carriers to bring their systems in line. To MHBE's knowledge, MHBE has selected a date that is not earlier than any carrier's current due date. MHBE also received agreement from a large Exchange carrier there was not an issue with the 7th of the month proposed date.
Carefirst	*.10E (9).* Delete. Same comment as above. Additionally, it is not clear what this means in a retroactive context – what is the 7th day of the prospective coverage month in a retroactive coverage?	Clarification edits added to specify that this refers to the first full prospective coverage month. For example, if the SEP is granted and a plan selection is made in April for a 2/1 start date, the payment is due by 5/7.
HEAU	14.35.07.10(E)(9) If a consumer qualifies for a retroactive SEP of several months it will likely take more than 7 days for a consumer to pay all back-dated premium payments to effectuate coverage. In fact, the FFM allows for payments "no earlier than 30 calendar days from the date the issuer received the enrollment transaction." The HEAU believes Marylander's deserve at least that minimum protection and that the additional language be added, "…no earlier than 30 calendar days from	Until 2018: This language mirrors the FFM language at 45 CFR 155.400(e) and MHBE does not accept the comment as this language already provides a broad range of time to pay the premium. 2018 and after: MHBE believes that specifying a uniform due date across carriers is the best approach to balancing 1) the importance of setting a uniform date that can be used by

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
	the date the issuer received the enrollment transaction, *or 30 calendar days from the date of invoice, whichever is later*."	MHBE for consumer messaging and will not be confusing to consumer's who switch plans between years or in an SEP and 2) the operational impact to carriers. If MHBE were to set a moving date - ie 15 calendar days after the date of the invoice - carriers would be challenged to record and act on dates that would vary by consumer and consumers would be required to calculate their own due date (and may not know when the issuer received the enrollment transaction).
Carefirst	.10(E)(10) - Delete. Carriers can only apply funds to the effective date that is received on the 834. Carriers can only effectuate prospective-only coverage, if the Exchange sends an updated 834 with the prospective effective date.	The proposed approach mirrors the FFM's approach. MHBE will work with carriers to ensure that the expected operational processes are in place to meet this requirement.
HEAU	The HEAU also requests the following addition to 14.35.07.10(E)(10) *"…and shall provide notice to the enrollee."*	Edit incorporated.
Carefirst	.10F A carrier may establish a premium payment threshold policy ~~*(1) Under the premium payment threshold policy the carrier may consider the enrollee to have paid all amounts due if the enrollee pays an amount sufficient to maintain a percentage of the total premium paid out of the total premium owed equal to or greater than a level determined by the carrier. (2) If establishing a premium payment threshold policy, the carrier shall: (a) Determine a level that is reasonable; and*~~ ~~*(b) Apply the level and the policy in a uniform manner to all enrollees*~~ *in accordance with 45 CFR § 155.400(g).* _____ Delete stricken words and add italicized words	MHBE believes it is important and appropriate to specify the requirements for the premium payment threshold policy within the regulation.
Carefirst	.10F(3). Delete.	

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
Carefirst	***.~~11~~2 Special Enrollment Periods~~—Loss of Minimum Essential Coverage or Termination of Other Specified Coverage~~.*** *A. An ~~qualified~~ individual ~~and, when specified in this regulation, the enrollee, the qualified individual or enrollee's dependent, are~~ may be eligible for a special enrollment period in accordance with:* *(1) Insurance Article Sections 15-1208.1, 15-1208.2 and 15-1316, Annotated Code of Maryland;* *(2) 45 CFR §§ 155.420(b)—(d);* *(3) 45 C.F.R. § 155.725(j); and* *(4) 45 CFR § 147.014(b).* _____ Delete stricken words and add italicized words. Delete the remainder of the regulation.	Edit not incorporated. 45 CFR Parts 155 and 156, among others, instruct the Exchange to make a decision based on the requirements identified within the regulation. Therefore, MHBE believes it must, under the Maryland Administrative Procedure Act, set forth regulations that alert individuals to the eligibility requirements MHBE will enforce. Please refer to the document regarding MHBE's approach to implementing federal requirements in state regulations for additional information about this approach, which may be found here: http://www.marylandhbe.com/policy-legislation/public-comment/. Further, the SEP rules in 45 CFR 155.420 provide many instances in which the Exchange must decide amongst multiple options allowed for by CMS in terms of SEP lengths and effective dates. MHBE found that in an attempt to use cross-references for some items and not for other items will be confusing and cumbersome to third parties.
Carefirst	Regulation .12 - Regulation .18 - Delete.	
HEAU	14.35.07.13(B),.14(A) and 15(A). While the HEAU appreciates that MHBE changed the notice requirement from 10 days to 30 days, the HEAU continues to object to a deadline in these instances. The federal regulations do not have a deadline and the proposed deadline is inconsistent with § 31-103(c)(3) of the Insurance Article. The federal regulations allow consumers 60 days from the date of discovery to notify the FFM of technical errors or misconduct, or other errors in attempts to terminate their plan.	The FFM requires for notice of the error, determination of the SEP eligibility and selection of the plan, if appropriate, within 60 days from the date of the event. MHBE has used a cross-reference to the CMS provision for 60 days for 2017 to mirror current forms submitted to MIA. For 2018 on, MHBE has attempted to break up the 60 days to ensure that a consumer has both sufficient time to provide notice to the Exchange of their potential eligibility for the SEP and the length of the SEP. Otherwise, MHBE believes that some consumers might be shortchanged on the length of the SEP if they are not afforded sufficient time to select the plan if they don't alert MHBE to the issue until later within the 60 days and/or the Exchange doesn't determine eligibility until later within the 60 days.

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
HEAU	14.35.07.13E(1) and .14D(1) and .15C. The HEAU requests the following addition to these sections(addition in italics): Shall be determined by the Exchange based on the circumstances of the [error, misrepresentation, or inaction] *and shall be on a date appropriate to the circumstances.* This request is consistent with federal regulations, 45 CFR 155.420.	Clarification edits incorporated to read: *E. The effective date of coverage for a qualified individual or the qualified individual's dependent who is determined eligible for an SEP under this regulation and selects a QHP or catastrophic plan during the SEP under §C of this regulation:* *(1) Shall be a date determined by the Individual Exchange as appropriate based on the circumstances of the error, misrepresentation, or inaction;* *Edit also allowed to misconduct, material violation and exceptional circumstance SEPS.*
HEAU	14.35.07.16 Exceptional Circumstances. The proposed regulation as currently worded suggests that the exceptional circumstances have to be current, when applying for enrollment, and not a previous impediment to enrollment. This category should not be time-limited and is not in the federal regulations. A time limit is unnecessary where the Exchange has discretion and where "exceptional" circumstances may prevent 30-days' notice.	Edit not incorporated. MHBE has aligned the circumstances under this SEP with federal guidance: https://www.regtap.info/uploads/library/ENR_SEPStreamliningIssuerVersion_050616_5CR_050616.pdf. 45 CFR 155.420(b)(1)(iii) applies the same SEP period to this SEP (45 CFR 155.420(d)(9)) as to other SEPs that MHBE has discretion to determine the SEP length and effective date (see e.g. 45 CFR 155.420(d)(4)).
Carefirst	**Regulation .20 *Authorized Representative.*** ~~Under COMAR 14.35.11.14,~~ An applicant or enrollee in the Exchange, ~~subject to federal and State privacy and security requirements,~~ may designate an individual or an organization to act ~~on the applicant or enrollee's behalf in applying for coverage and in carrying out all other ongoing communications with the Exchange~~ as the applicant or enrollee's authorized representative in accordance with COMAR 14.35.11.14. _____ Delete stricken words	Edits incorporated.

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
Kaiser Permanente	We urge that regulatory text be added to each of Chapters 7 and 14 to make clear that the intent of the chapters is to mirror federal requirements, that in the event of a conflict between the state regulations and federal requirements deference will be given to QHP issuers acting in good faith to meet federal requirements, and that the intent of these regulations specifically is not to create any additional obligations on issuers or rights for any individual not otherwise available under federal rules.	A scope provision at 14.35.01.01 is added to capture these comments.
Kaiser Permanente	All of the areas covered by the proposed MHBE regulations - eligibility, enrollment, special enrollment periods "SEPs"), effective dates, and grounds for terminations, cancellations and rescission of coverage – are already addressed in many complex federal rules and sub-regulatory guidances, as well as state laws, and re-printing them in state regulations is redundant and likely to cause confusion. All of these areas are heavily regulated by federal requirements already. Some of these topics, e.g., SEPs, also are specifically covered by existing Maryland statutes applicable on and off the Exchange. Adding these same requirements to the regulations is not necessary and could increase the possibility for confusion and inconsistency among the requirements, which could harm enrollees (as well as create unnecessary business and compliance risks for QHP issuers). We urge MHBE to avoid importing the federal rules into these state regulations for the wide range of issues where the Exchange is mandated by federal rules and does not have discretion to vary from those federal rules (e.g., where the federal rules clearly state "The Exchange must determine . . ." or "The Exchange must permit . . .", etc.). Instead, MHBE should consider adopting a more streamlined set of state regulations that cover only those specific elements for which the Exchange has discretion to determine what rules it will apply – e.g., under 45 CFR 155.310, the Exchange has discretion to fix the period of notice provided to applicants who submit incomplete applicants of no less than 10 days and no more than 90 days, so we	Edit not incorporated. 45 CFR Parts 155 and 156, among others, instruct the Exchange to make a decision based on the requirements identified within the regulation. Therefore, MHBE believes it must, under the Maryland Administrative Procedure Act, set forth regulations that alert individuals to the eligibility requirements MHBE will enforce. Please refer to the document regarding MHBE's approach to implementing federal requirements in state regulations for additional information about this approach, which may be found here: http://www.marylandhbe.com/policy-legislation/public-comment/.

Round 2: 14.35.07 COMMENTS Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
	would expect the MHBE regulations to clearly state what notice period it has adopted for this purpose.	