



**MARYLAND HEALTH BENEFIT EXCHANGE RESPONSES TO INFORMAL PUBLIC COMMENTS ON PROPOSED COMAR
14.35.14**

The following charts summarize informal public comments submitted to Maryland Health Benefit Exchange (MHBE) based on two versions of proposed COMAR 14.35.14. The first chart includes comments submitted by April 27, 2016 in advance of the May 17, 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	League = The League of Life and Health Insurers of Maryland	MIA = Maryland Insurance Administrat
---	--	---	---

Summary of Comments Received and MHBE Response to Comments

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
Carefirst, MIA, HEAU	General Comment - If requirements repeat federal law, request to use cross-references or mirror federal text exactly.	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

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
		here: http://www.marylandhbe.com/policy-legislation/public-comment/ .
Carefirst	14.35.14.01 provides that the chapter applies to terminations, cancellations or rescissions of enrollment of an individual enrolled through the Exchange. It does not, however, clearly indicate that it only applies to individuals enrolled in individual (as compared to small group) plans. CareFirst recommends that .01 be modified to specify that the chapter only applies to terminations, cancellations and rescissions through the Individual Exchange.	Chapter only intended to pertain to individual exchange plans, reference added to Individual Exchange in scope.
MIA	14.35.14.01 - The term Maryland Health Connection, which is used in the last line, needs to be defined.	Reference amended to "Individual Exchange".
MIA	14.35.14.02 - The definitions should be placed in alphabetical order.	New definitions incorporated within definitions proposed for removal (because they are captured in 14.35.01.02) and in alphabetical order.
Chris Keen, League, Carefirst, MIA	14.35.14.03(A). 14.35.14.03(B) requires carriers to "honor" an individual's request to terminate coverage "without affecting the status of any other member of the individual enrollee's household". First, The League questions the logic of having insureds enroll with the Exchange but able to terminate with the carrier. This seems to add a layer of complexity to the relationship and new opportunities for problems. Without the opportunity for testing of systems and clear understanding of how these various terminations can occur, implementation of these provisions is premature. In addition, it is unclear how carriers would operationalize these terminations of some but not all covered lives under the policy if the individual requesting the termination is the policyholder. A health insurance policy is fundamentally a contract like any other between specified parties- here the parties are the carrier and the policyholder who is considered to be the ultimate decision maker for the policy. This concept is apparent throughout Maryland health insurance law. In	<p>Enrollees must be permitted to terminate their coverage under 45 CFR 155.430(b)(1)(i). Enrollees may request termination through the carrier now. "Honor" amended to "process" for clarification.</p> <p>Carriers and MHBE currently have an established manual process. When an individual/household requests termination, the carrier will send a paper form to the Exchange capturing the information about the individual/household who requested termination.</p> <p>For household termination requests made on and after 1/1/17, carriers and MHBE are working to establish an automated process whereby the carrier will be able to send an automated termination 834 to MHBE with a code indicating that the household requested the termination. MHBE will use this file to update its records.</p>

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
	<p>fact, in proposed COMAR 31.10.01.02 (B)(5) specifically indicates that the policyholder is the person to whom the carrier's contract is issued.</p> <p>Split households can create complex scenarios that lead to manual workarounds. In addition, APTC eligible households are concerning if carriers are terminating them, as carriers cannot redetermine households' APTC eligibility. Moreover, this would violate Maryland law, which provides that the policyholder is the person to whom the carrier's contract is issued. MD. CODE REGS. 31.10.01.02(B)(5). Much of a carrier's obligation under its contract is with the policyholder. See, e.g., MD. CODE REGS. 31.10.01.03(S) and 31.10.13.13 (changes of premium to the policyholder only, MD. CODE REGS. 31.10.01.03(S) and 31.10.28.05 (policyholder determines premium payment mechanism).</p>	<p>Individual members of a household requesting termination of enrollment in a multi-member enrollment will only be processed by MHBE. MHBE has amended this requirement and will not require carriers to directly process these requests.</p>
Carefirst	<p>14.35.14.03(C) requires carrier to maintain for 10 years "records of termination of enrollment in a QHP". This standard is too vague for carriers to implement. It is not clear if all documentation and correspondence with the Exchange, such as 834s, are included in this requirement. CareFirst requests that the Exchange clarify what "records" must be maintained.</p>	<p>As noted in the rule, MHBE will specify a format for the records under 45 CFR 155.430(c)(1).</p>
Carefirst	<p>14.35.14.03(E) provides that a carrier must accept the Exchange's adjusted calculation for APTC, CSR, and premiums for retroactive termination dates. In January 2016, the EIAC requested comment on the ability of consumers to initiate terminations with carriers and carriers push termination 834s to the Exchange. In response, in January 2016 CareFirst provided detailed comments to the Exchange concluding that the Exchange should focus on the stability of the EDI transactions currently in place before building further functionality in the system. CareFirst believes now and indicated at that time that there have been a number of EDI compliance errors</p>	<p>MHBE believes this comment pertains to F.</p> <p>Carriers must process all enrollment files sent to them by the Exchange, including terminations (45 CFR 155.430(a), (b) and (c)) and retroactive changes to enrollment, including if they affect CSR and APTC (45 CFR 156.425(a), 45 CFR 156.460(a)). This may require premium credits due to the consumer or additional amounts due by the consumer to the carrier as accounted for under 45 CFR 156.425(a) and 45 CFR 156.460(a) and it may require APTC adjustment between a carrier and IRS.</p>

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
	<p>for termination files that have been discussed over the last year. The system has not regularly sent correct termination files, which has caused a high volume of manual work for our EDI team. CareFirst also noted in January 2016 that this issue is also far more complex than it appears, particularly for split households (one member needs to be terminated- either primary or a dependent). As noted above, it is unclear who the "policy holder" would be under Maryland law if the consumer who is currently defined as the policyholder voluntarily terminates his or her enrollment. Split households can create complex scenarios that lead to manual workarounds on both sides. In addition, APTC eligible households are concerning if carriers are terminating them with reason code 14, as carriers cannot re-determine households' APTC eligibility. The only consumers who could be terminated with reason code 14 are full households. Completing a full testing cycle with these complex scenarios could take several months based on previous testing cycles. CareFirst therefore requested in January 2016 that it would prefer that this requirement be delayed until 2018, at the earliest, to allow for the process to be fully worked through on the Plan Management Stakeholder Committee and MIA input. During the March 2, 2016 Plan Management Stakeholder Committee Meeting, the Exchange identified a multi-step process for carriers to begin accepting terminations from consumers and sending them to the Exchange. Carriers were required to inform the Exchange of a date that they will be able to submit an implementation plan and testing timeline by March 31, 2016. Carriers asked for more detail before being able to provide the requested information. It is unclear how the regulations can move forward without taking into account the feedback the Exchange asked for. Despite all of these concerns that CareFirst raised, the draft regulation implements this requirement immediately.</p>	<p>Please refer to comments above pertaining to the termination process for requests made to the carrier.</p>

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
HEAU	14.35.14.03(F) - Is there an avenue for them to raise a discrepancy concern?	An individual may appeal a determination under COMAR 14.35.11.
Carefirst	14.35.14.03(F) requires carriers to accept the Exchange's adjusted APTC, CSR and premium calculations. Again, the regulation is overly broad and doesn't take into consideration the legal and operational concerns it raises. Carriers can accept the exchange's dates, but the regulation should not be implemented until further details can be provided by the exchange including the MIA's position that it will not take enforcement action against carriers for their inability to send timely termination notices to members when the date of termination is in the past. Additionally, CSRs cannot be recalculated as they are reflected in a plan. The prepayment amount should also not change, as it is reconciled between the carrier and CMS based on actual claims data. Retroactive APTC adjustments could result in the termination of a policy if the retroactive date is greater than 60 days and the APTC is adjusted downward. It also leaves carriers having to collect premiums months after the member's coverage was in effect. CareFirst understands that any retroactive adjustments in APTC would occur at the time the member files their taxes.	<p>Carriers must process all enrollment files sent to them by the Exchange, including terminations (45 CFR 155.430(a), (b) and (c)) and retroactive changes to enrollment, including if they affect CSR and APTC (45 CFR 156.425(a), 45 CFR 156.460(a)). This may require premium credits due to the consumer or additional amounts due by the consumer to the carrier as accounted for under 45 CFR 156.425(a) and 45 CFR 156.460(a) and it may require APTC adjustment between a carrier and IRS.</p> <p>The inclusion to CSR refers to the CSR-variant of a QHP and does not pertain to CSR payments from CMS. Edits incorporated to specify that changes in the plan variation of the QHP may be provided and the definition of "plan variation" included in 14.35.01.02.</p>
Carefirst	14.35.14.04 appears to replace the Exchange's previous policy regarding member-initiated terminations. The Exchange plan management stakeholder meeting presentation on March 3, 2016 provided that carriers would not be required to send 834s, with reason code 14, to the Exchange until November 1, 2016 and that this process would not be fully integrated until January 1, 2017. These dates are not reflected in .04 and therefore the regulation is inconsistent with existing Exchange policy and its recognition of the operational challenges voluntary terminations pose to earners. As CareFirst has indicated previously, CareFirst believes that the Exchange should focus on the stability of the EDI transactions	Please refer to comments above regarding voluntary terminations.

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
	<p>currently in place before building further functionality in the system. At this time, there have been a number of EDI compliance errors for termination files that have been discussed over the last year. The system has not regularly sent correct termination files, which has caused a high volume of manual work for our EDI team. This issue is also far more complex than it appears, particularly for split households (one member needs to be terminated- either primary or a dependent). It is unclear who the "policyholder" would be under Maryland law if the consumer who is currently defined as the policyholder voluntarily terminates his or her enrollment. Split households can create complex scenarios that lead to manual workarounds on both sides. In addition, APTC eligible households are concerning if carriers are terminating them with reason code 14, as carriers cannot re-determine households' APTC eligibility. The only consumers who could be terminated with reason code 14 are full households. Completing a full testing cycle with these complex scenarios could take a couple of months based on previous testing cycles. Due to these concerns, CareFirst would prefer that this requirement be delayed until 2018, at the earliest, to allow for the process to be fully worked through on the Plan Management Stakeholder Committee and MIA input.</p>	
Chris Keen	<p>14.35.14.04(A) - [Carrier] does not allow an individual's request to terminate coverage, requires that termination be sent by the Exchange.</p>	Please refer to comments above regarding voluntary terminations.
MIA	<p>14.35.14.04(A) - The word "select" should be substituted for the "direct" in the second line.</p>	Edit incorporated.
HEAU	<p>14.35.14.04(A) - It should be clear the consumer can terminate through either the exchange or the carrier. This is implied here but not affirmatively stated.</p>	Incorporated within newly proposed B.

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
Carefirst	14.35.14.04(B) is not necessary and is unduly complicated, as it is substantively repetitive of, but does not mirror the language of, existing federal and State law. This is likely to cause unnecessary conflicting application of the governing federal regulations and confusion. See MD. CODE ANN, INS. § 15-1315(c) (as is being amended by HB 801).	.04B(now amended to C) includes effective dates for enrollee requested terminations while Ins. Art. 15-1315(c) as amended covers grace periods.
Chris Keen	14.35.14.04(B)(1) - [Carrier] does not allow an individual's request to terminate coverage, requires that termination be sent by the Exchange.	Please refer to comments above regarding voluntary terminations.
Chris Keen	14.35.14.04(B)(2)(a) - I don't believe a mid-month termination is currently allowed. Will a monthly premium be charged pro-rata? Can the APTC be a pro-rated? Example: Request a termination May 1 on April 25th. Coverage ends May 8th. What premiums and APTC are due for first 8 days of May?	Mid-month terminations are appropriate in many circumstances, including death, changes in plans due to birth, or an enrollee termination request made at least 14 days in advance of the requested date. A mid-month termination would require premium and APTC pro-ration.
Chris Keen	14.35.14.04(D) - Is the change of plan deemed a brand new application requiring new IPP requirements and loss of the grace period if with the same carrier? If so, why should a change of policy cause a loss of grace period protection?	If the deceased member is the primary enrollee/subscriber, the remaining household members may re-enroll under a loss of MEC SEP and would be enrolling in a new plan under current contract requirements in COMAR 31.10.01.02B(5).
HEAU	14.35.14.04(D) - Many of the proposals attempt to mirror the federal regulations but because they are not exactly the same unintended problems are introduced – such as in this example. These would be much easier, cleaner and consistent if they just referred to the federal regulations where intended and supplemented with state-specific additions.	Proposed D (now amended to E) mirrors the federal regulation for the effective date of terminations due to death under 45 CFR 155.430(d)(7). Additions to the proposed rule include that notice may be provided by the policyholder, enrollee over 18 or an authorized rep may provide the notification under 45 CFR 155.430(b)(1)(iii). COMAR 14.35.11.14A(1) broadly means “individual or organization acting responsibly on behalf of the applicant in accordance with this regulation, in assisting with an applicant’s application, renewal of eligibility, appeals, and other ongoing communications with the Exchange.”

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
HEAU	14.35.14.04(E) - These regulations do not address an opportunity for a retroactive termination date. The 2017 Notice of Benefit and Payment Parameters have additions for retroactive terminations that should be included for Maryland consumers.	New additions at 45 CFR 155.430(b)(1)(iv) and (d)(9) added as newly designated Regulation .05.
MIA	14.35.14.05 - This Regulation appears to work only for the individual market. Where are the rules for termination of coverage for those covered under contracts purchased through the SHOP Exchange?	Regulations for the SHOP Exchange will be addressed in a subsequent chapter.
MIA	14.35.14.05(B) - The word “renewal” should be substituted for the word “selection” in the first line. This does not appear to be referring to when the individual is selecting a new plan, but renewing a current plan.	Language mirrors 45 CFR 155.430(b)(1)(ii). This event may happen at any time during the year if the individual reports that he/she is newly eligible for MEC.
MIA	14.35.14.05(C) - This section appears to contradict Regulation .04. It would seem that this section should also mention the right of the enrollee to terminate coverage as described in Regulation .04.	Reference to enrollee-requested termination in .04 added to newly designated .06 (previously .05).
MIA	14.35.14.05(D) - This section appears to be incomplete. One of the frequent complaints that the MIA has received deals with the family where one family member wants to terminate coverage when he or she becomes eligible for Medicare. However, this cause of termination is not listed in this section.	Enrollee-requested terminations (which may be for any reason including new Medicare eligibility) are included in .04 and a new reference to .04 added to newly designated .06 (previously .05) for clarity. Reference already incorporated into .07 (previously .06).
Chris Keen	14.35.14.05(D) - Will a monthly premium be charged pro-rata? Can the APTC be a pro-rated if not end of month?	Mid-month terminations are appropriate in many circumstances, including death, changes in plans due to birth, or an enrollee termination request made at least 14 days in advance of the requested date. A mid-month termination would require premium and APTC pro-ration.
HEAU	14.35.14.05(D)(1) - Federal rules include this language – again just referencing the federal rules would eliminate inadvertent errors.	Edits incorporated into new .05 and revised .06-.07 to mirror 45 CFR 155.430.

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
HEAU	14.35.14.05(D)(2) - I do not believe this is consistent with rescission rules at 147.128.	Rescission reference mirrors 45 CFR 155.430(b)(2)(iii).
MIA	14.35.14.06 - This section appears to be incomplete. One of the frequent complaints that the MIA has received deals with the family where one family member wants to terminate coverage when he or she becomes eligible for Medicare. However, this cause of termination is not listed in this section. This Regulation appears to work only for the individual market. Where are the rules for termination of coverage for those covered under contracts purchased through the SHOP Exchange?	<p>Enrollee-requested terminations (which may be for any reason including new Medicare eligibility) are included in .04 and a new reference to .04 added to newly designated .06 (previously .05) for clarity. Reference already incorporated into .07 (previously .06).</p> <p>SHOP rules will be included in a separate chapter at a later date.</p>
League	14.35.14.06(A) limits termination of an on-Exchange enrollee to terminations at the member's request or for nonpayment of premium. This inappropriately limits the permissible reasons for which a carrier can terminate an enrollee under federal law. Important reasons such as "[t]he enrollee is no longer eligible for coverage in a QHP through the Exchange" and "[t]he enrollee's coverage is rescinded" in accordance with federal regulations have been omitted.	Rescission added to regulation. As the carrier will not determine if the consumer is no longer eligible for coverage through the Exchange, this provision is only included in the Exchange-initiated terminations regulation (.06).
Carefirst	14.35.14.06(A) provides that carriers may only terminate an on-Exchange enrollee at the member's request or for nonpayment of premium. This is inconsistent with the list of permissible reasons a carrier may terminate coverage under 45 CFR §155.430 (b)(2). Moreover, voluntary terminations for reasons other than nonpayment of premium should be directed centrally to the Exchange and not to individual carriers to minimize the potential for conflicting enrollment information.	<p>The proposed rule allows the carrier to terminate for non-payment (there is no request from the consumer required) (see .07(A)).</p> <p>Reasons included under .07 mirror 45 CFR 155.430(b)(2) that would not require the Exchange to initiate the termination.</p> <p>Please refer to comments above regarding voluntary termination requests.</p>
Chris Keen	14.35.14.06(A)(1) - Carefirst requires the termination come from the exchange. Does not allow a voluntary term to the carrier.	Please refer to comments above regarding voluntary termination requests.

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
MIA, HEAU	<p>14.35.14.06(B)(1) - This item is dealing with when a carrier may terminate coverage for nonpayment of premium.</p> <p>a. It would seem that item (a) should be deleted, as it is incomplete. It does not discuss the grace period.</p> <p>b. It would appear that this item should be revised to describe the two different grace periods—the one that applies if the individual is receiving advance payments of the premium tax credit and the one that applies if the person is not receiving advance payments of the premium tax credits.</p> <p>c. The reference to § 31-115(c) through (e) of the Insurance Article in item (b) is incorrect. The correct reference would be § 15-1315(c) through (e) of the Insurance Article.</p>	Edits incorporated to clarify that “all other applicable grace periods” refers to those not receiving APTC and specific Insurance Article and COMAR citations included for individuals not receiving APTC. Reference to 15-1315 corrected.
Chris Keen	14.35.14.06(B)(1)(b) - Can you provide the three-month grace period rules referred to? Googled and didn't find.	Maryland Insurance Article, 15-1315(c) through (e) and 45 CFR 156.270(g).
Chris Keen	14.35.14.06(B)(2) - Why if a member changes plan does a different binder payment timeframe apply than if they do not change a plan? It seems logical that if you “change” a plan more time is needed and not less to make an initial premium payment. Bills for the month may need to be adjusted, new bills generated, and more time needed to make a binder payment, not less.	A new plan requires a binder payment. Renewal in the current plan (the variation for the new year) doesn't require a binder payment because it is a continuation of the same plan/enrollment/contract.
Carefirst	14.35.14.06(B)(2) provides that a carrier may not terminate renewing coverage for nonpayment of premium for failure to make a "binder payment". Binder payments are not required for renewals. This term should be modified to provide a "payment" rather than a "binder payment" and reference the applicable grace period available to the renewing member.	Edits incorporated to reflect that termination at renewal should follow the grace period requirements for APTC (3 months) or non APTC (31 days).
HEAU	14.35.14.06(B)(2) - See HB 801.	Edit incorporated regarding “when first failing to pay premium...”

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
MIA	14.35.14.06(B)(2) - This item is incorrect. The carrier may not require a new binder payment if the individual renews into the same “product” as described in the federal regulations. It would appear that a definition of “product” is needed and a revision so that the carrier is not terminating renewing coverage for failure to pay a binder premium.	Edits incorporated. Definition of product added and language included to note that same product is a product that follows the uniform modification provision under 15-1309(4).
HEAU	14.35.14.06(B)(2) - Not always the same plan. Federal guidance says passive enrollment in new product b/c original product not available.	Edits incorporated to reflect that termination at renewal should follow grace period requirements and binder payment not required for applicable grace period. Edits incorporated to define product.
MIA	14.35.14.06(C) - For the purpose of clarity, the words “of premium” should be added to the end of the lead-in statement.	Edit incorporated.
MIA	14.35.14.06(C) - Item 1 is incorrect. A carrier is not permitted to terminate an individual’s coverage simply because the same plan is no longer sold on the Exchange. The words “that coverage” would seem to convey this intent. While 45 CFR § 147.106(b)(4), which is cited in this item, deals with termination of a product, this text does not do so. Once again, a definition of “product” is needed and a termination in compliance with 45 CFR § 147.106 should be added.	Definition of “product” under Ins. Art 15-1309(a)(3)(i) added to .02B(4). “That coverage” amended to “the QHP that the enrollee is enrolled in”. Additional text added to clarify no longer offering 1 product vs leaving the market and the process to follow for these events under new .07C(1)(b) and (c).
MIA	14.35.14.06(C) - The use of the word “coverage” does not work in item 1 because it is defined in COMAR 14.35.01.02B(17) to mean that the qualified individual is enrolled in a qualified plan. Since qualified individuals are found only on the Individual Exchange, this type of requirement would be appropriate only for the Individual Exchange.	Amended to “the QHP that the enrollee is enrolled in”.
Brenda A. Wilson (MIA)	14.35.14.06(C) - Item 2 is incomplete in that it omits the intentional misrepresentation of material fact as found in 45 CFR § 147.106(b)(2).	Edits incorporated in new .07(A)(6).

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
MIA	14.35.14.06(C) - The list appears to be incomplete for the individual market. It would seem that the carrier should be permitted to terminate coverage if the enrollee is no longer eligible for coverage in a QHP as set forth in 45 CFR 155.430(b)(2)(i).	Newly designated .07 (previously .06) only includes the termination reasons where the carrier would not first require the Exchange to tell the carrier to terminate the coverage. As such, reasons including moving from 1 QHP to another and leaving the QHP's service area are determined by the Exchange and are included in .06 (previously .05) and not .07.
HEAU	14.35.14.06(C)(5) - Effective dates unclear and this could cause problems.	Clarification edits added to regulation to specify the date and corresponding termination reason.
MIA	14.35.14.07(A) - Incomplete. It lists that the individual's coverage may only be cancelled for certain reasons. However, the list of reasons does not include the fact that the individual's enrollment may be cancelled for fraud or for intentional misrepresentation of material fact. See 45 CFR § 147.106(b)(2).	Edits incorporated to include 147.106(b)(2) reasons.
Chris Keen	14.35.14.07(A)(2) - Can you provide the rules referred to in this passage? Similar to .06B2 above with more time needed and not less time.	A new plan enrollment (except if it is the same plan or product as part of a renewal) requires an initial premium payment.
HEAU, MIA	14.35.14.07(A)(2) - Shop? (HEAU); The term "enrollment group" should be defined. (MIA)	SHOP will be addressed in a separate chapter at a later date. "Enrollment group" reference deleted.
MIA	14.35.14.07(A)(2) - The end of this item lists two references which are supposed to establish specific dates. However, neither reference specifies a specific date. The federal cite 45 CFR § 155.400(e) merely states that Exchanges may establish a standard policy for setting premium payment guidelines. The COMAR reference does not deal with this issue either. It was drafted to prohibit an insurer from requiring payment before a due date. The COMAR cite also would not apply to nonprofit health service plans, dental plan organizations or HMOs.	MHBE proposes the premium payment deadline standards that mirror the FFM's approach under 45 CFR 155.400(e) for until 2018. For 2018, MHBE proposes to set a specific date deadline that will be uniform across carriers.

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
Brenda A. Wilson (MIA)	14.35.14.07(A)(2) - Comment 13 also applies to the legal citations listed in Regulation .07C. It is also questionable how an individual could “notify the Exchange or carrier of the request to cancel on or before the premium due date.” If the individual did not want the coverage to begin and it did begin, how could the individual notify the Exchange or carrier before the due date to cancel the coverage? This would seem to be an issue where the individual finds out after the fact and cannot terminate unwanted coverage.	Cross-reference added to capture premium due dates set forth in COMAR 14.35.07.10E.
MIA	14.35.14.08 - We would recommend deleting item A(1) for two reasons. First, the reference to § 15-210 of the Insurance Article is applicable to only insurers. It does not apply to nonprofit health service plans, HMOs, or dental plan organizations. Second, Section 15-210 of the Insurance Article does not require that an insurer reinstate coverage. Instead, it merely requires that a provision appear in the contract permitting the individual to ask to be reinstated. The carrier can say “no.”	References incorporated for COMAR 31.10.25.04C (for nonprofit health services plans) and COMAR 31.12.07.05D (for HMOs).
MIA	14.35.14.08 - Item A(3) appears to be incomplete. The words “or cancellation” should be added to the end, after the word “termination.”	Edit incorporated.
HEAU	14.35.14.08(A)(1) - This has limited application, need to include HMOs, non-profits, etc.	References incorporated for COMAR 31.10.25.04C (for nonprofit health services plans) and COMAR 31.12.07.05D (for HMOs),
HEAU	14.35.14.08(B) - But you need notice right?	Yes, notice is captured in A for an individual request. A carrier will send an 834 termination file to MHBE.
Carefirst	14.35.14.08(B) requires a carrier to process a reinstatement without requiring Exchange action. On multiple occasions, including as late as February 29, 2016, CareFirst informed the Exchange that we are unable to reinstate members without a transaction from the Exchange as it is the source of truth. If no Exchange action is	MHBE is working with carriers to ensure that the carrier and MHBE have automated functionality for the carrier to send MHBE the reinstate/add 834 where appropriate. In the interim, MHBE has worked closely with carriers to set up a manual process by which the carrier identifies individuals/enrollment groups eligible for reinstatement, sends MHBE

Round 1: 14.35.14 COMMENTS Submitted by April 27, 2016		
Source	Comment	MHBE Response
	required, the Exchange will not be able to know the enrollment has been reinstated: the last data exchange with the Exchange will show that the member is terminated. This will create source of truth problems and potential significant downstream implications for the Exchange, the carrier and the member. This will be especially problematic when CMS starts sending carriers APTC and CSR payments based on Exchange enrollment data resulting in carrier underpayments.	the list of those individuals and MHBE creates and sends the 834 add file to the carrier for processing.
Carefirst	14.35.14.09 provides that the Exchange may suspend or revoke a carrier's certification, or impose other penalties against a carrier, for failing to follow the Chapter's requirements. However, MD. CODE, INS. § 31-115(k) (I)(ii) limits the Exchange's authority to take any of these actions if the basis for action is "under the regulatory and enforcement authority of the Commissioner." The section should clearly indicate that the Exchange has limited enforcement authority only to the extent the MIA does not regulate the field.	MHBE and MIA have joint authority on certain provisions. Language in COMAR 14.35.16.13 and Ins. Art. 31-115(k) are drafted in such a way that capture this relationship.
MIA	14.35.14.09 - We are unable to find COMAR 14.35.19.14. Is this a correct reference?	Reference updated to 14.35.16.13.

Round 2: 14.35.14 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	Edit incorporated into revisions to 14.35.01.01.

Round 2: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
	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.	
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 applications of no less than 10 days and no more than 90 days, so we would	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: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
	expect the MHBE regulations to clearly state what notice period it has adopted for this purpose.	
League	Ongoing concerns with the consumer initiated termination proposal. Thank you for the thoughtful consideration of concerns raised at the May 17 th meeting and the revised policy circulated by email on May 23 rd . League members have continued to share concerns with the proposed policy. It is our belief that the revised policy remains a significant departure from required processes in all other Exchanges and places a unique burden on carriers participating in the Maryland market. Further, the proposed policy regarding accumulators leaves unanswered implementation and operational questions for carriers. The League urges the MHBE to look more closely at the proposal and the implications and challenges the policy poses for QHPs.	Based on feedback from stakeholders, MHBE has amended the carrier processing of consumer termination requests to apply only to whole household termination requests. This mirrors current operational processes and MHBE and carriers have been working, and are on track, to automate this process by 1/2017.
HEAU	Email from MHBE re: Carrier processing of enrollee-requested terminations. The HEAU understands that MHBE will only require carriers to accept and process whole-household termination requests directly from the enrollee without requiring that the enrollee first notify the Exchange but the HEAU requests that in other instances, the carrier should be required to accept the termination request and pass on the request to the Exchange. Or, at a minimum, the consumer should be provided with an easy way to notify the Exchange of a termination request, one that does not require long wait times for a CSR.	Carriers will be instructed to inform the consumer that they should contact the Exchange to request termination of 1 member from a multi-member enrollment. This is their current process.
Carefirst	The revised draft Chapter requires carriers to perform two specific functions that to our knowledge no other exchange in the country requires or is even contemplating requiring. Carriers would be required to (1) allow consumers to	MHBE is working to ensure that all operational materials align with these regulations.

Round 2: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
	voluntarily terminate their coverage directly with the carrier and (2) maintain dependents on policies and carry over their accumulators when the policyholder terminates coverage. Over the past several months, CareFirst has discussed and	Under 45 CFR 155.430(e), CMS states that an Exchange may specify a termination process for itself and carriers that corresponded with the technical and operational capacity and preference of each Exchange. CMS removed the original explicit requirement that both the Exchange and

	<p>provided detailed written feedback to the Exchange about our serious concerns with these proposals, which have overlapping legal and operational problems. Previous Comments about the Proposals Have Not Been Addressed. The Areas of Concern Create Policy that is Significantly Different from All Other Exchanges and Federal. The Areas of Concern are Inconsistent With Other Exchange Policy Documents</p>	<p>carriers process any enrollee-requested terminations under 45 CFR 155.430(b)(1)(i). Under the original contracts, carriers were required to process all consumer-initiated terminations and should have had this capability to be in compliance with their contractual obligations and federal law. MHBE has allowed carriers to use a manual process to accomplish this requirement and has been working with carriers to implement automated functionality for whole household terminations by 2017. Based on feedback from stakeholders and the amendment to CMS requirements, MHBE has limited its proposal to require only that carriers continue to process whole household termination requests. Partial household termination requests will be processed by the Exchange given the current technical capabilities of the Exchange and its partner carriers.</p> <p>Additionally, 45 CFR 155.430(b)(1)(i) requires the Exchange to allow “an enrollee” to terminate his/her coverage and 45 CFR 155.430(b)(2) requires the Exchange to terminate “an enrollee” from coverage if he/she is no longer eligible, among other reasons. Under 45 CFR 155.20, “enrollee” means “a qualified individual enrolled in a QHP” and “qualified individual” means “an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market”. While carrier contracts are constructed around the policyholder (who is simply labeled as such if they are the adult who completes the application for the household through Maryland Health Connection and consumers are often not aware of this status), this distinction is recognized nowhere in federal regulations. MHBE has worked closely with the Maryland Insurance Administration to propose multiple solutions to stakeholders that would both satisfy the federal requirements of termination at the enrollee level while not disrupting the state-only contract construct. Additionally, MHBE already addressed this issue in the context of terminations due to a policyholder’s termination for an outstanding citizenship or immigration verification in the 2017 issuer letter. It is MHBE’s understanding that carriers already apply this policy to other scenarios across markets - such as when the policyholder dies or is newly eligible for Medicare. One large Individual Exchange QHP carrier also expressed interest in expanding this policy to these additional scenarios after MHBE’s 2017 issuer letter was released. Further, the Maryland Insurance Administration has worked with carriers to manually move the accumulators between contracts when the</p>
--	--	--

		<p>policyholder is terminated in certain instances when the household appeals to MIA for this relief. MHBE believes that the type of relief crafted by the MIA is appropriate not just on a case-by case basis. Finally, the FFM allows consumers to replace the “household contact” or remove the household contact when others wish to remain enrolled (see https://www.healthcare.gov/reporting-changes/cancel-plan/#notreplacing).</p> <p>All other household members enrolled in the plan should not be punished simply because they were not the primary enrollee of the account and, therefore, not identified as the policyholder and therefore MHBE seeks to ensure that appropriate relief on this issue is available to all. MHBE has proposed a multi-phase approach to this requirement to reduce the burden on carriers while protecting consumers under the requirements of the federal regulations.</p>
--	--	--

Round 2: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
Carefirst	Put definitions in alphabetical order. CareFirst previously submitted a definition of "product" to 14.35.01.02.	Definitions in alphabetical order. Definition of product removed and covered in 14.35.01.02.
Carefirst	Reg .03 (A-B) - Per discussion in the May 17th meeting, such a broad requirement cannot be implemented by carriers. Currently, accumulator carryover requirements only exist in two very limited circumstances, 1) movement within silver plan variants and 2) citizenship eligibility data matching inconsistencies. Any further accumulator carryover requirements must be specifically discussed and vetted with carriers to assess operational, technical, and legal implications. These discussions previously began during the Implementation Advisory and Plan Management Advisory Committee meetings, but were never completed CareFirst continues to be prepared to discuss specific scenarios with the Exchange, but is not able to implement the requirements without these discussions. Please see CareFirst cover letter summarizing our legal and operational concerns with accumulator carryovers for further elaboration.	Please refer to response above regarding policyholder terminations.
Carefirst	An authorized carrier shall maintain records of termination of enrollment in a QHP and catastrophic plan in the format specified by the Exchange for a period of ten years Delete stricken text. As discussed in the May 17th meeting, format should not change from initial creation. Does not need to be separately specified.	Edit incorporated.
Carefirst	Reg .03E - In May 17th meeting, the MHBE agreed that a mutually agreed to format must be created to allow for implementation.	Edit incorporated.

Round 2: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
Carefirst	<p>For all retroactive terminations, the Exchange shall inform the enrollee and the individual requesting the retroactive termination if not the enrollee that the enrollee may be responsible for paying for all medical services rendered to the enrollee and the enrollee's dependents as of the coverage termination date</p> <hr/> <p>Add the text above to Reg .03E</p>	MHBE believes that this information is best addressed under consumer assistance worker training requirements and could be provided through consumer assistance channels.
Carefirst	<p>An enrollee may terminate the enrollee's coverage in a QHP or catastrophic plan at any time and may select the date of termination if the enrollee provides notice to the Exchange or to the authorized carrier at least 14 days prior to the requested termination date <i>as specified in Section C of this Regulation</i></p> <hr/> <p>Delete the stricken text and add the italicized text. MHBE indicated this would be acceptable during May 17th meeting. Edits to B to allow policyholder only to terminate entire household coverage through carrier or Exchange notices.</p>	Edits incorporated.
Carefirst	Reg .04 - Please see CareFirst cover letter summarizing our legal and operational concerns with consumer initiated terminations	MHBE believes that it's suggested approach balances consumer and carrier burden under the Exchange's ability to direct termination processes in 45 CFR 155.400(d)(12). MHBE will require carriers to process whole household terminations, which is line with work already undertaken through MHBE's Plan Management team with carriers and MHBE has removed the requirement that carriers have to process individual member termination requests.
HEAU	14.35.14.04(C) Date of Terminations - (2) Paragraph 2 is unclear and could be read to mean the request is made prior to 14 days in advance rather than as intended, that the consumer is seeking a termination date in fewer than 14 days.	Edits incorporated except proposed for (3) in .06 and (e) in .05 kept in original location.

Round 2: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
	This should be clarified to read, "If the enrollee requests a termination date <i>in fewer than 14 days...</i> "	
Carefirst	Reg .04 D - Numerous edits to appropriately align to 45 CFR 155.430(d)	Edits incorporated except proposed for (3) in .06 and (e) in .05 kept in original location.
HEAU	14.35.14.04(D) - The HEAU requests the following addition to the end of D: "...unless an earlier termination date is requested by the enrollee and granted by the carrier consistent with paragraph C."	Clarification edits incorporated.
HEAU	14.35.14.05(D) - The Exchange has included a notification date that could be harmful to consumers and is unnecessary to specify at this time. The HEAU envisions a consumer becoming aware of their unknown enrollment when they receive a late 1095A or undergo a tax audit that would likely occur after April tax filings for the preceding year.	The federal rule under 45 CFR 155.430 allows the Exchange to specify a date that balances operational needs and consumer protection. MHBE believes that the proposed date allows for sufficient time for a consumer to identify that they've been erroneously enrolled in a plan while ensuring that the Exchange and carriers are provided with a specified time for which they must address retroactive terminations under this requirement. This date is consistent with the limitation of error SEPs under FFM guidance for retroactive effective dates in the previous calendar year as well.
HEAU	14.35.14.05(F)(1) – mislabeled as the second E - The HEAU requests the following addition (in italics): "... no sooner than 14 days after the date that the enrollee <i>can demonstrate</i> that the enrollee contacted..." This addition of federal language clarifies that the 14 days is from the original notification date, not the later notification date after the technical problem is discovered.	Edits incorporated.
Carefirst	Reg .06(B)(9) " <i>Becomes eligible for other minimum essential coverage but does not request termination in accordance with Regulation. 04 of this chapter</i> "	Edits incorporated.

Round 2: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
	This is a separate reason for termination than movement outside service area. Also, This occurs at time of eligibility for other MEC, not at time of plan selection	
Carefirst	Reg .06(C/D) - In May 17th meeting, MHBE agreed that this was a voluntary termination under section .04	Edit incorporated.
Carefirst	Reg .06 (D)(4-5) - In May 17th meeting, MHBE agreed that this was a voluntary termination under section .04	Edit incorporated.
Carefirst	Reg .06 (D)(6) - This section discusses terminations, not cancellations	Edit incorporated.
HEAU	14.35.14.06(E)(5) (misabeled as 2 nd D) - The HEAU requests the following addition to the end of D: "...unless an earlier termination date is requested by the enrollee and granted by the carrier consistent with paragraph .04C."	Edit incorporated.
Carefirst	Reg .07(A)(3-5) - In May 17th meeting, MHBE agreed that these were scenarios where the carrier should not be able or responsible for termination.	Edits incorporated.
HEAU	14.35.14.07(B) - (1) The language is inaccurate and suggests that consumers, when they first fail to pay premiums, has already exhausted the 3 month grace period. The HEAU suggests the following revision: An authorized carrier may terminate coverage for nonpayment of premium in accordance with the terms of the contract if the enrollee has not made applicable premium payments and: (a) The three-month grace period required under Insurance Article § 31-1315 (c) through (e) for enrollees, who when first failing to timely pay premiums, are receiving advance payment of the premium tax credits, has been exhausted; or	Language removed as circuitous and this edit discussed at May 17 meeting.

Round 2: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
	(b) The applicable 31-day grace period under Insurance Article § 15-209, COMAR 31.10.25.04C or COMAR 31.12.07.05D has been exhausted.	
Carefirst	Reg .07(B)(2) - In May 17th meeting, MHBE agreed that this was circuitous and already covered under section .07(B)(l) above.	Edit incorporated.
Carefirst	Reg .07(D)(1) and (3) - In May 17'h meeting, MHBE agreed that this is not covered under B of this regulation, so should be struck.	Edits incorporated.
Carefirst	Reg .08(B) - In May 17th meeting, MHBE agreed that this could create conflict with binder payment deadlines. If consumers can only cancel until 15th of month prior, could be construed as limiting ability to effectuate coverage via payment after that deadline	Edits incorporated to mirror termination dates - last day of month prior to original effective date for entire household cancellations and 15th of the month for individual member cancellations.
HEAU	14.35.14.08(B) - Consumers can effectuate cancellation of a non-issued policy just by failing to pay the premium. Consumers should not be required under these regulations to notify the Exchange by the 15 th of the month prior to the date coverage begins to obtain a cancellation. What are the consequences to the consumer if they fail to notify the Exchange?	A consumer must indicate that they no longer wish to enroll in the QHP in order to ensure that they can timely select another QHP. MHBE must send the cancellation to the carrier in order for the carrier to process a new plan selection with the same carrier. However, MHBE believes this language must remain in the regulation to provide consumer protection when the consumer wishes to change plans within an enrollment period.
Carefirst	Reg .09(A) - See MIA 4/8/16 comment III(15), which clarifies that a carrier is not obligated to reinstate coverage at the request under Insurance Article § 15-210.	Edits incorporated to add specificity that carrier should process reinstatement if carrier already processed termination. MHBE has been working with carriers to address this situation initially with incorrect terminations for nonpayment.

Round 2: 14.35.14 COMMENTS Submitted by May 23, 2016		
Source	Comment	MHBE Response
Carefirst	Reg .09(A)(2) - In May 17th meeting, MHBE agreed that this should appropriately reference all Exchange entities as previously in regulation.	Edit incorporated.
HEAU	14.35.14.09(A)(2) should include all arms of the Exchange	Edit incorporated.
Carefirst	Reg .09(B) - Must be clear that the Exchange must process the reinstatement. Carriers are not able to process on-Exchange reinstatements.	Edits incorporated to add specificity that carrier should process reinstatement if carrier already processed termination. MHBE has been working with carriers to address this situation initially with incorrect terminations for nonpayment.
Carefirst	Reg .09(C)- In May 17 th meeting, MHBE agreed that payment requirement must be referenced in this section of regulation	Edit incorporated.