MARYLAND HEALTH BENEFIT EXCHANGE RESPONSES TO INFORMAL PUBLIC COMMENTS ON PROPOSED REGULATIONS IN GENERAL AND PROPOSED COMAR 14.35.01.02

The following charts summarize informal public comments submitted to Maryland Health Benefit Exchange (MHBE) about the proposed regulations in general and based on two versions of proposed COMAR 14.35.01.02. The first chart includes general comments received. The second chart includes comments submitted by April 27, 2016 in advance of the May 17, 2016 meeting and the third 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 Administration

Summary of Comments Received and MHBE Response to Comments - GENERAL COMMENTS

General Comments		
Source	**Comment**	**MHBE Response**
Planned Parenthood (Robyn Elliot)	make sure that the process for determining eligibility and enrollment for domestic abuse victims is streamlined	MHBE thanks the stakeholder for support of the current text draft. As proposed, MHBE has incorporated federal rules and guidance on domestic

Women's Law Center of Maryland	Careful consideration should be given to how a victim of domestic violence would have easy and understandable eligibility and access to the exchange for enrollment. Unnecessary or burdensome processes for proving they are victims may cause them to lose access to services they need.	violence and spousal abandonment APTC and SEP provisions. MHBE looks forward to continued dialogue to ensure that this population of consumers do not face barriers to the eligibility and enrollment process.
Kaiser Permanente	We are concerned that federal regulations and CMS guidance are issued from time to time that alter the requirements or interpretation of federal regulations; therefore, there likely will be material discrepancies between state and federal rules that affect enrollees and QHP issuers during the lag time between the issuance of federal updates and when conforming changes can be adopted into these state counterpart requirements.	As MHBE staff have already undertaken in ensuring that the Maryland Health Connection system and corresponding training and other materials are updated to correspond to any changes in federal requirements, MHBE will continue to monitor federal changes and incorporate them into regular state regulatory changes similar to other state agencies' current process. MHBE has also added text within the regulations - in the Scope at 14.35.01.01 and for example, the open enrollment provisions at 14.35.07.11 - to reflect that the provisions are subject to changes in federal law, regulations and guidance.
Kaiser Permanente	We also are concerned that the proposed state rules do not strictly mirror federal rules, which creates the potential for additional or different compliance requirements. These factors leave QHP issuers with the risk of potential non-compliance with state laws as they strive to stay current in compliance with federal requirements. We would expect MHBE and the Maryland Insurance Administration (MIA) to defer to current federal rules and interpretations in any enforcement actions involving QHP issuers acting in good faith to meet both federal and state requirements. We also would expect that MHBE would be explicit in the event it were adopting a state law requirement that extends beyond the requirements imposed by federal law. Similarly, we are concerned that individuals not be granted rights under state law beyond those provided under federal law, except with explicit advance notice and comment opportunity. The proposed "Scope" sections of the draft regulations do not sufficiently address these various concerns.	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/. MHBE has addressed

League, Carefirst	**Ongoing concerns with the regulatory approach.** During the discussion on the proposed regulations, the MHBE shared its position that it would attempt to codify federal regulations and guidance into Maryland regulations and that it would not do so through cross reference or verbatim incorporation of federal requirements. The League remains concerned about the challenges and unintended consequences that may be caused by discrepancies and inconsistencies created by incomplete codification of federal requirements in the Maryland regulations. As Maryland regulations have the force of law, it is important that the language used be complete and legally sufficient and track the federal requirements fully. The audience for regulations are the regulators and the regulated. MHBE regulations must serve as appropriate regulatory guidance to the QHPs charge with complying with the regulations. State regulations that do not track completely federal requirements create compliance risk for carriers and remain a paramount concern. If appropriate cross references are not used, it is imperative that the incorporation of federal requirements be complete and that only those changes to the language necessary to meet Maryland style requirements be made. Each change becomes a potential deviation from the federal requirement and can leave QHP's unable to comply with federal and state requirements simultaneously.	this comment by adding text to the Scope at 14.35.01.01.

Summary of Comments Received and MHBE Response to Comments - PROPOSED 14.35.01.02

Round 1: Proposed 14.35.01.02 Comments Submitted by April 27, 2016		
Source	**Comment**	**MHBE Response**
MIA	**14.35.01 -** Since new definitions are being added to § 31-101 of the Insurance Article each year, it would avoid future amendments to these regulations if each reference to the Insurance Article is only to the section as opposed to the subsection listing the definition.	Edits incorporated.
MIA	**14.35.01 -** While this version was amended to try and show new text in italicized type, it did not succeed. The following numbered definitions are new, but are shown as already adopted definitions: (2), (4), (5), (11), (12), (16), (17), (19), (20), (21), (25), (26), (27), (28), (38), (40), (43), (44), (46), (48) and (49). The old numbers do not appear in this draft either - it should show the numbered definitions as they appear in the currently adopted regulations. If new	Edits incorporated.

	definitions are added, then the old numbers should be bracketed to show that they were deleted and new numbers added in italicized type to indicate that they are new. Otherwise, it is extremely difficult to determine what is being changed.	
HEAU	**14.35.01.02** - Binder payments are not required for passive or active renewals into the same plan or "new product because the old product is no longer available". This definition suggests a binder payment would be required for a new product even if passively renewed into the product. Suggestion for consideration/ discussion – "the first month's payment required to effectuate enrollment, other than renewal, in a qualified health plan."	Definition removed. Requirements pertaining to premium payment deadlines are captured within COMAR 14.35.07.10E.
MIA	**14.35.01.02(B)(6) -** The "binder payment" definition is not clear. The words "that an enrollee is renewing" should be substituted for the word "renewed" in the last line. Additionally, the definition uses the term "product," which is not defined.	Definition removed. Requirements pertaining to premium payment deadlines are captured within COMAR 14.35.07.10E.
Carefirst	**14.35.01.02(B)(6) -** defines binder payment as a payment that it not for the same plan or product. However, a consumer does not need to make a binder payment when renewing into a new plan, just a new product. Accordingly, the definition should be revised to remove "same plan or".	Definition removed. Requirements pertaining to premium payment deadlines are captured within COMAR 14.35.07.10E.
MIA	**14.35.01.02(B)(8) -** The term "Board of Trustees" is defined to have the meaning stated in § 31-101(b) of the Insurance Article. However, this term is not defined in that reference. Instead, the defined term in § 31-101 is the term "Board."	Edit incorporated to only use the term "Board" within COMAR 14.35.01.02.
Carefirst	**14.35.01.02 (B)(8)** and **(9)** both define "enrollee" almost identically. One definition should be removed.	Definitions included for "enrollee" and "qualified individual" as a qualified individual may not be enrolled in coverage.
MIA	**14.35.01.09 -** The "Exchange" definition was deleted - it should have been listed as original definition (9).	Exchange definition edited to mean MHBE.
Carefirst	**14.35.01.02(B)(14)** defines cost sharing as "expenditures required by or on behalf of an enrollee with respect to essential health benefits". Deductibles, copays and coinsurance apply to all benefits under a member's health benefit plan regardless of whether they are essential health benefits or not. The phrase "with respect to essential health benefits" should be deleted.	Edit incorporated.

MIA	**14.35.01.02(B)(15) -** Why is the definition being changed from the current definition, which is a cross reference to the definition in federal regulations? The new definition follows the federal regulations, but the change seems unnecessary and may require future amendments if the federal regulations change.	The language of the federal regulations is being adopted here instead of a cross-reference for readability since cost sharing is defined directly above CSR with text in lieu of a cross-reference.
MIA	**14.35.01.02(B)(16) -** The word “enrolled” should be substituted for the word “enrollment” in the “coverage” definition.	Edit incorporated.
MIA	**14.35.01.02(B)(19) -** The new “dependent” definition is a cross reference to 26 CFR § 54.9801-2. However, this definition does not work for your regulations, as it only refers to someone who can be covered under the group’s health plan. Since most of the references to “dependent” in the various MHBE regulations deal with individual coverage, this definition is inappropriate.	Definition removed and added to COMAR 14.35.07.02 for Regulations .11-.18 as definition is intended to apply only for SEPs and mirrors 45 CFR 155.420(a)(2).
MIA	**14.35.01.02(B)(20)-(21) -** Both of these definition define the same term “enrollee.” Only one definition should appear. Also, the definition does not work for small group plans, since not all individuals enrolling in small group plans through the Exchange would satisfy the definition of a qualified individual.	Edits made to the term “enrollment” to clarify that the enrollment refers to the coverage and the “enrollee” refers to the individual enrolled in the coverage.
Carefirst	**14.35.01.02(B)(22)** defines enrollment as an individual's "coverage through the Exchange". An individual is not covered through the Exchange but enrolls in coverage through the Exchange. An individual is covered by a carrier.	Edit incorporated.
Carefirst	**14.35.01.02(B)(24)** - definition of grace period is very confusing. CareFirst recommends it be modified to point to the Maryland Insurance Article provisions for ease of reference.	MIA suggested edits incorporated.
MIA	**14.35.01.02(B)(24) -** **a.** Is the definition of “grace period” supposed to work for both individual and small group plans? If so, the citations listed in the definition apply only to individual coverage.	Definition is only intended for individual plans. Edits incorporated to reflect that term applies to individual plans and words “due to nonpayment of premiums” added.

	b. For purposes of clarity, the words "due to nonpayment of premiums" should be added to the end of this definition. The carrier could terminate the individuals from coverage for other reasons during this time period.	
MIA	**14.35.01.02(B)(32) -** The cite in this definition is incorrect. It should refer to § 31-101(j) of the Insurance Article.	This item refers to the Individual Navigator which is at 31-101(i) while the certification is under 31-101(j).
MIA	**14.35.01.02(B)(45) -** The new definition of "qualified individual" contradicts § 31-101(s) of the Insurance Article. The current definition in the adopted regulations is correct.	
MIA	**14.35.01.02(B)(47) -** The definition of "single, streamlined application form" is not a complete thought.	Clarification edits incorporated.
MIA	**14.35.01.02(B)(48) -** The definition of "special enrollment period" needs to be clarified to indicate that it applies only outside the open enrollment period.	Edits incorporated.
Carefirst	**14.35.01.02(B)(48)** defines a special enrollment period as the period an individual can enroll in a qualified plan. Special enrollment periods, however, are only the periods to enroll outside the open enrollment period. This should be clarified.	Edits incorporated.

Round 2: 14.35.01.02 COMMENTS - Submitted by May 23, 2016		
Source	**Comment**	**MHBE Response**
Carefirst	*2) "Actuarial value" means the percentage paid by a health plan of the percentage of the total allowed costs of benefits in accordance with 45 CFR § 156.140.*[BML1] [BML1]Adding this definition is necessary if the MHBE requires in chapter 15 a provision about which metal level coverage each carrier may offer. This is already required under the Insurance Article and therefore CareFirst recommends that restating these requirements is unnecessarily duplicative. However, if the MHBE requires a description	Edit incorporated.

	of bronze, silver and gold plans to be in MHBE regulations that a carrier must sell, the terms need to be accurately defined.	
Carefirst	*(3) "Advance payments of the premium tax credit (APTC)" means payment of the federal tax credits authorized by 26 U.S.C. §36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a qualified health plan through the Exchange under section 1412 of the Affordable Care Act.* ____ There are two definitions of APTC. The second does not align with the definition in 45 CFR § 155.20, but the first does. Also, the second definition is not new text but existing regulation so should not be italicized to the extent it is maintained.	Used definition that aligns with federal definition.
Carefirst	*(6) "Binder payment" means the first month's payment required to effectuate enrollment in a new qualified health plan that is not the same product renewed for the new calendar year. [BML1]* [BML1] Binder payment is not used in Chapters 1 or 7. It will need to be deleted and the definitions below renumbered if it is not also used in the forthcoming modified draft Chapters 14-17.	Deleted as first month's premium payment is used in 14.35.07 only.
Carefirst	*(7) "Board" has the meaning stated in Insurance Article, §31-101*[BML1] *, Annotated Code of Maryland.*[BML2] [BML1] Deletion based off the MIA's recommendation that subsections not be referenced to avoid the need for future changes if the statute is amended in the future. See MIA 4/8/16 comments, I(5). [BML2] Board of Trustees is not a defined term in 31-101(b). The defined term is "Board".	Edit incorporated.
Carefirst	*(12) "Certification standard" means a process, procedure, requirement or condition of participation in the Exchange under COMAR 14.35.15 or COMAR 14.35.16.* ____	Edit not incorporated.

	Recommend against having "standard" and "certification standard" be different terms, particularly as "standard" means a "certification standard".	
Carefirst	*(1) (a) "Cost sharing" means any expenditure required by or on behalf of an enrollee with respect to covered* [BML1] *benefits.* [BML1] Cost sharing applies to all covered benefits, not just those benefit that are EHB.	Edits incorporated.
Carefirst	***[**(7)**]** (15) "Cost-sharing reductions (CSR)" **[**has the meaning stated in 45 CFR §155.20**]** means reductions in cost sharing for an eligible individual enrolled in a silver level plan through the Exchange or for an individual who is an Indian enrolled in a QHP through the Exchange. [BML1]* [BML1] The MIA requested that the previous definition citing back to the federal regulation be maintained. See MIA 4/8/16 comments I(6).	Edits not incorporated related to eligibility which is covered in 14.35.07.
Carefirst	*(18) "Dependent" has the meaning stated in 26 CFR §54.9801-2.*[BML1] [BML1] The MIA indicated this was not the appropriate cross-reference, as it only pertains to someone who can be covered under the group's health plan. See MIA 4/8/16 comments I(8). CareFirst notes, however, that 45 CFR § 155.420(a)(2), in identifying the general requirements for SEPs, provides: For the purpose of this section, "dependent", has the same meaning as it does in 26 CFR 54.9801-2, referring to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee. Although CareFirst cannot identify a better definition of "dependent" for the individual market, it does not object to the citation provided by the MHBE.	Edit incorporated.
Carefirst	*"Eligibility determination" means a decision by the Exchange about an applicant's eligibility to enroll in a QHP or insurance affordability program or terminate a qualified individual's enrollment in a QHP or insurance affordability program* ________________________________ Add the words " *during the open enrollment period or special enrollment period* "	Edit incorporated.

Carefirst	*(21) "Enrollment" means the qualified individual's coverage* ***<u>in a QHP, catastrophic plan, or insurance affordability program purchased</u>*** *through the Exchange* ____ Add the bolded and underlined words	Edit incorporated.
Carefirst	**[**(9)**]** *(22) (a)* "Exchange" **[**has the meaning stated in Insurance Article §31-101(e), Annotated Code of Maryland**]** *means the Maryland Health Benefit Exchange* ____ Add the words: *"established as a public corporation under Insurance Article § 31-102, Annotated Code of Maryland.* *(b) "Exchange" includes:* *(i) The Individual Exchange; and* *(ii) The Small Business Health Options Program (SHOP Exchange."* because this is the definition in Md. Insurance Code § 31-101(e).	Edit incorporated.
Carefirst	**Insert the following:** *(24) "Gold health plan" means a health plan that has an actuarial value of 80 percent.* [BML1] ____ [BML1] See 45 CFR § 156.140.	Edit incorporated.
Carefirst	*(25) "Grace period" means the period of time during which a carrier is prohibited from terminating an enrollee's enrollment in a qualified plan* ***<u>obtained through the Individual</u>*** **<u>[BML1]</u>** ***<u>Exchange for nonpayment of premium</u>*** [BML2] *, as specified in….* Add the underlined/bolded words above [BML1] The MHBE will need to decide if it also wants to address grace periods in the group market. If so, further changes to this definition will be needed. [BML2] See MIA 4/8/16 comment I(11).	Edit incorporated.

Carefirst	*(27) "Health Information Exchange" means the State-designated health information exchange.* [BML1] [BML1] Where is this term defined? CareFirst was unable to identify its use in .02, .07, .14, .15, or .16.	Term used within proposed 14.35.16 and designated under state law.
Carefirst	**Delete:** (41) "Maryland Health Benefit Exchange" **[BML1]** **[BML1]** This appears repetitive to the definition in .02(B)(21).	Both Exchange and MHBE are definitions.
Carefirst	*(44) "Plain language" has the meaning stated in § 1311(e)(3)(B) of the Affordable Care Act* [BML1] . [BML1] Recommend either referring to the statute as the ACA or Affordable Care Act, but not both for consistency purposes.	Affordable Care Act used.
Carefirst	*(45) "Plan variation" means a zero cost sharing plan variation* [BML1] *or a silver plan variation.* [BML1] As limited cost share plan variation is a silver plan variation, this does not need to be separately identified from the silver plan variation.	Edit incorporated.
Carefirst	**Insert the following:** *(46) "Product" has the meaning stated in 45 CFR § 154.102.*	Edit incorporated.
Carefirst	[(23)] *(49)* "Qualified Individual" [has the meaning stated in Insurance Article, §31-101(s), Annotated Code of Maryland] ***means an individual means an individual, including a minor, who at the time of enrollment:*** ***(a) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;*** ***(b) Resides in the State;***	MIA definition incorporated.

	<u>(c) Is not incarcerated, other than incarceration pending disposition of charges; and</u> ***<u>(d) Is, and reasonably is expected to be for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States</u>*****<u>. [BML1]</u>** Add the bolded/underlined words above **[BML1]** This is the definition in Md. Insurance Code 31-101(s). See also MIA 4/8/16 comments I(13).	
Carefirst	*(51) "****<u>Silver health plan" is a health plan that has an actuarial value of 70 percent</u>****.* [BML1] Add the bolded/underlined words above [BML1] See 45 CFR § 156.140.	Edit incorporated.
Carefirst	*(54) "SHOP Exchange" has the meaning stated in Insurance Article, 31-101*[BML1] *, Annotated Code of Maryland.* [BML1] Deletion based off the MIA's recommendation that subsections not be referenced to avoid the need for future changes if the statute is amended in the future. See MIA 4/8/16 comments, I(5).	Edit incorporated.
Carefirst	Delete *(54) "Standard Plan". This definition is no longer needed because of the additions of separate definitions for bronze, silver and gold plans.*	Edit incorporated.
Carefirst	*(55) "Single, streamlined application form" means the eligibility application* ***<u>form an applicant may use to apply</u>*** *for Medicaid, MCHP, qualified health plans, stand-alone dental plans, APTC, or CSR through the Exchange.* Add the bolded/underlined words above	Edit incorporated.
Carefirst	*(56) "Special enrollment period" means the period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Exchange outside of the open enrollment period.* [BML1]	Edit incorporated.

	[BML1] This is the definition in 45 CFR § 156.20. See also MIA 4/8/16 comments I(15).	
Carefirst	*"Zero cost sharing plan variation" means the cost-sharing reduction plan variation of a QHP under 45 CFR §156.420(b)(1).* [BML1] [BML1] Where is this term defined? CareFirst was unable to identify its use in Chapters .01. .07, .14, .15 or .16.	Addressed in definition of plan variation.