Title 14 INDEPENDENT AGENCIES

Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE

Chapter 07 Eligibility and Enrollment for Enrollment in Qualified Plan, Advance Premium Tax Credits and Cost-Sharing Reductions

Authority: Insurance Article, §§ 31-106(c)(1)(iv); 31-108(b)(1); 31-108(b)(10); 31-108(b)(17), Annotated Code of Maryland

.01 [Information Required for Eligibility Determination.] *Scope*.

[A. In determining an individual's eligibility for a qualified plan or Maryland Medicaid, including determinations for advanced premium tax credit and cost sharing reductions, the Exchange may verify information regarding the individual, including information on an individual's:

(1) Social Security Number;

(2) Date of birth;

(3) Household size;

(4) Employment status;

(5) Lawful residency;

(6) Immigration status;

(7) Incarceration status;

(8) Income; and

(9) Eligibility for disability and other public assistance benefits.

B. The Exchange may use State and federal data systems in verifying the information listed in §A of this regulation, including the following data systems:

(1) Medicaid Management Information System;

(2) The Service Access Information Link;

(3) CARES;

(4) Maryland Vehicle Administration;

(4) JAIL MATCH;

(5) Maryland Lottery;

(6) Systematic Alien Verification for Entitlements; and

(7) Federal Data Hub System, including Internal Revenue Service data.]

This chapter sets forth the eligibility standards for enrollment in qualified health plans, advance payments of the premium tax credit, and cost-sharing reductions. This chapter does not address verification of eligibility or redeterminations of eligibility.

.02 Definitions.

A. In this chapter, the following terms have the meanings indicated.

B. Terms Defined.

(1) "Catastrophic plan" means a health plan offered under section 1302(e) of the Affordable Care Act that:

(a) does not provide a bronze, silver, gold, or platinum level of coverage;

(b) the only individuals who are eligible to enroll in the plan are individuals who have not attained the age of 30 before the beginning of the plan year or who have qualified for an affordability or hardship exemption from HHS; and

(c) the plan provides for the coverage of essential health benefits, except that the plan provides no benefits for any plan year until the individual has incurred cost-sharing expenses in an amount equal to the annual limitation in effect for the plan year (except for the coverage of at least three primary care visits and as provided for in section 2713 of the ACA).

(2) "COBRA" means the Consolidated Omnibus Budget Reconciliation Act of 1985 (Pub. L. 99-272).

(3) "CSR plan for up to 150% FPL" means a qualified health plan with an average cost sharing value of 94% of covered out-of-pocket costs for the enrollee.

(4) "CSR plan for 151-200% FPL" means a qualified health plan with an average cost sharing value of 84% of covered out-of-pocket costs for the enrollee.

(5) "CSR plan for 201-250% FPL" means a qualified health plan with an average cost sharing value of 73% of covered out-of-pocket costs for the enrollee.

(6) "Employer group health insurance coverage" means coverage for an employee, or the employee's dependents if eligible, under a governmental plan, such as the Federal Employees Health Benefit program, a plan or coverage offered in the small or large group market within a state, or a grandfathered health plan offered in a group market.

(7) "Federal poverty line" means the most recently published poverty guidelines (updated periodically in the FEDERAL REGISTER by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2)) as of the first day of the regular enrollment period for coverage by a qualified health plan offered through an Exchange for a calendar year.

(8) "Household income" has the meaning under section 36B(d)(2) of the Internal Revenue Code.

(9) "Indian" means an individual who is a member of an any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians.

(10) "Institution" means an establishment that furnishes food, shelter, and some health treatment or services to four or more persons unrelated to the proprietor.

(11) "Insurance affordability programs" means the Medical Assistance program, Maryland Children's Health Insurance Program, advance premium tax credits and cost-sharing reductions.

(12) "Minimum essential coverage" has the meaning under 26 CFR §1.36B-2(a)(2) and (c)

(13) "Non-applicant" means an individual who is not seeking to enroll in a qualified plan through the Exchange.

(14) "Silver-level QHP" means a type of metal level plan that:

(a) provides an average cost sharing value of 70% of covered out-of-pocket costs for the enrollee; and

(b) an individual must enroll in to access cost-sharing reductions, if the individual is eligible for cost-sharing reductions.

(15) "Rescission" means a cancellation or discontinuance of coverage that has retroactive effect and meets a permissible circumstance under 45 CFR §147.128.

(16) "Tax filer" means an individual, or a married couple, who indicates that he, she or they expects:

(a) To file an income tax return for the benefit year, in accordance with 26 U.S.C. 6011, 6012, and implementing regulations;

(b) If married (within the meaning of 26 CFR §1.7703-1), to file a joint tax return for the benefit year, except if the spouse is victim of domestic violence or spousal abandonment;

(c) no other taxpayer will be able to claim him, her or them as a tax dependent for the benefit year; and

(d) to claim a personal exemption deduction under section 151 of the Internal Revenue Code on the tax filer's return for one or more applicants, even if the tax filer is not an applicant.

(17) "Qualifying eligible employer-sponsored plan" means a plan that meets the requirements under 26 CFR §1.36B-2(c)(2)(i).

.03 Applying for coverage.

A. Individuals may apply for coverage through the Exchange using the single, streamlined application form approved by the Exchange.

B. Individuals may submit the application by telephone, internet website, in-person assistance including provision of reasonable accommodations, or mail.

C. Applicants must provide the following information on the application:

(1) Social security number, if the individual has a Social Security number;

(2) Authorization for the Exchange to verify attested information through electronic means;

(3) An election indicating whether the applicant is seeking an eligibility determination for enrollment in a qualified health plan, insurance affordability programs, or both;

(4) Sufficient information to determine eligibility for enrollment in a qualified health plan or insurance affordability programs;

(5) An attestation that the individual, or married couple, if the individual is part of a married couple, intends to file an income tax return for the benefit year in which the individual is seeking coverage, except:

(a) If a spouse is the victim of domestic violence or spousal abandonment, the spouse may indicate that the spouse is single; and

(b) If the individual in a married couple qualifies to file as head of household; and

(6) Signature, including either an electronic or telephonic signature, under penalties of perjury.

D. Non-Applicant.

(1) A non-applicant may need to provide information on the application to determine eligibility for insurance affordability programs even if the individual is not seeking coverage on the Exchange if members of the individual's tax filing household are seeking eligibility for insurance affordability programs, including:

(a) the non-applicant's name; and

(b) the non-applicant's social security number, if the applicant attests that the tax filer has a social security number and filed a tax return for the year for which tax data would be used for verification of household income and family size.

(2) A non-applicant may need to provide information on the application even if the individual is not seeking coverage if the only other members of the individual's household seeking coverage are under the age of 18 and are not emancipated minors, including:

(a) The non-applicant's name; and

(b) The non-applicant's address.

(3) Applicants are not required to provide information about citizenship, status as a national, or immigration status of an individual in the household who is not seeking coverage.

E. An individual applying for eligibility in insurance affordability programs may not elect to receive an eligibility determination for less than all of the insurance affordability programs.

F. An individual may seek an eligibility determination for coverage through the Exchange at any time during the year by submitting an application to the Exchange.

G. If an individual submits an incomplete application, the individual has 90 days from the date notice is sent to the individual informing the individual the application is incomplete to complete the application for eligibility.

.04 Notice Requirements.

A. The Exchange shall provide timely written notice to an applicant of any eligibility determination made in accordance with this chapter as described in COMAR 14.35.11.04.

B. The Exchange shall notify an employer that an employee has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions upon determination that an employee is eligible for advance payments of the premium tax credit or cost-sharing reductions.

C. The notice under §B of this regulation shall:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for advance payments of the premium tax credit or cost-sharing reductions;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under section 4980H of the Internal Revenue Code; and

(4) Notify the employer of the right to appeal the determination to HHS.

D. An applicant who submits an application containing insufficient information for the Exchange to conduct an eligibility determination shall receive a notice:

(1) Indicating that information necessary to complete an eligibility determination is missing;

(2) specifying the missing information;

(3) providing instructions on how to provide the missing information; and

(4) specifying that the information must be provided within 90 days of the date the notice under Regulation .03(F) of this chapter to complete the application.

E. If the applicant or enrollee has designated an authorized representative under Regulation .20 of this chapter, the Exchange shall provide:

(1) Information both to the applicant or enrollee, and to the authorized representative, regarding the powers and duties of authorized representatives; and

(2) Notices under this regulation both to the applicant or enrollee, and to the authorized representative.

F. Written notice may be provided electronically if an applicant or employer so elects and:

(1) The individual confirms the election by mail;

(2) The individual is informed of the right to change the election;

(3) Notices are posted in the individual's account within one business day of generation of the notice;

(4) A notification that contains no confidential information is sent to the individual's verified e-mail address alerting the individual to the existence of the notice;

(5) If the electronic communication fails, a written notice will be sent to the mailing address; and

(6) Written versions of electronic notices are available upon request.

.05 Eligibility Requirements for Enrollment in a Qualified Health Plan.

A. An applicant is eligible for enrollment in a QHP through the Exchange if the applicant meets the following requirements:

(1) The applicant is:

(a) a citizen or national of the United States, or

(b) a non-citizen who is lawfully present in the United States, and

(2) is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

B. The applicant is not incarcerated, other than incarceration pending the disposition of charges; and

C. The applicant is a resident of the Exchange service area.

D. Eligibility under this regulation is contingent upon verification of the applicant's attestation of the applicant's information.

.05 General Eligibility Requirements—Citizenship and Immigration Status.

A. For purposes of eligibility for enrollment in a QHP, APTC or cost-sharing reductions, an individual shall be considered a citizen or national of the United States as specified .04(A)(1) and (3) of this chapter if the individual is:

(1) A citizen of the United States, including:

(a) An individual who was born in:

(i) One of the 50 states;

(ii) The District of Columbia;

(iii) Puerto Rico;

(iv) Guam;

(v) The Northern Mariana Islands; or

(vi) The Virgin Islands;

(b) A child born outside of the United States if:

(i) The federal requirements, including the requirements in the Child Citizenship Act of 2000 (Public Law 106-395), are met for the child to automatically acquire United States citizenship upon the child's lawful admission to the United States for permanent residence;

(ii) At least one of the child's natural, adoptive, or stepparents is a United States citizen by birth or naturalization;

(iii) The child is younger than 18 years old;

(iv) The child is residing in the United States in the legal and physical custody of the citizen or naturalized parent; and

(v) The child is a lawful permanent resident of the United States;

(2) An individual who has been naturalized as a United States citizen; or

(3) A national from American Samoa or Swain's Island.

B. For purposes of eligibility for enrollment in a QHP, APTC or cost-sharing reductions, an individual is lawfully present as specified in .04(A)(2) and (3) of this chapter if the individual is:

(1) An alien lawfully admitted to the United States for permanent residence or who since admission was granted lawful permanent resident status in accordance with the Immigration Nationality Act (INA);

(2) An alien granted parole for at least 1 year under §212(d)(5) of the INA;

(3) An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. 1182(d)(5)) for less than 1 year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;

(4) An alien who was battered or subjected to extreme cruelty by the individual's United States citizen or lawful permanent resident spouse or parent, or by a member of the spouse's or parent's family residing in the same household as the immigrant, if:

(a) The spouse or parent consented to, or acquiesced in, the battery or cruelty;

(b) The abusive act or acts occurred in the United States;

(c) The individual responsible for the battery or cruelty no longer lives in the same household as the victim;

(d) A Violence Against Women Act immigration case or a family-based visa petition has been filed; and

(5) A refugees admitted under §207 of the INA;

(6) An alien granted asylum under §208 of the INA;

(7) An alien whose deportation is being withheld under:

(a) §243(h) of the INA as in effect prior to April 1, 1997; or

(b) §241(b)(3) of the INA, as amended;

(8) A Cuban or Haitian entrant, as defined at §501(e) of the Refugee Education Assistance Act of 1980;

(9) An alien granted conditional entry under §203(a)(7) of the INA in effect before April 1, 1980;

(10) A child receiving federal payments for foster care or adoption assistance under Part B or E of Title IV of the Social Security Act, if the child's foster or adoptive parent is considered a citizen or qualified alien;

(11) A victim of a severe form of trafficking, in accordance with §107(b)(1) of the Trafficking Victims Protection Act of 2000, who have been subjected to:

(a) Sex trafficking if the act is induced by force, fraud, or coercion, or the individual who was induced to perform the act was younger than 18 years old on the date that the visa application was filed; or

(b) Involuntary servitude.

(12) An alien in nonimmigrant status who has not violated the terms of the status under which he or she was admitted or to which he or she has changed after admission;

(13) An alien currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. 1160 or 1255a, respectively);

(14) An alien currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. 1254a), and pending applicants for TPS who have been granted employment authorization;

(15) An alien who has been granted employment authorization under 8 CFR 274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(16) A Family Unity beneficiary pursuant to section 301 of Public Law 101-649, as amended;

(17) An alien currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;

(18) An alien currently in deferred action status;

(19) An alien whose visa petitions have been approved and who have a pending application for adjustment of status;

(20) A pending applicant for asylum under section 208(a) of the INA (8 U.S.C. 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;

(21) An alien who has been granted withholding of removal under the Convention Against Torture; or

(22) A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. 1101(a)(27)(J)).

.06 General Eligibility Requirements—Residency in Exchange Service Area.

A. For purposes of eligibility for enrollment in a QHP, an individual shall be considered a resident of the Exchange service area as specified in .04(C) of this chapter:

(1) If an individual is age 21 and over, is not living in an institution, is capable of indicating intent, and is not receiving an optional State supplementary payment and:

(a) the individual lives in the Exchange service area,

(b) Intends to reside in the Exchange service area, including without a fixed address; or

(c) Has entered with a job commitment or is seeking employment (whether or not currently employed).

(2) If an individual is under the age of 21, is not living in an institution, is not eligible for Medicaid based on receipt of assistance under title IV-E of the Social Security Act, is not emancipated, is not receiving an optional State supplementary payment and:

(a) resides in the Exchange service area, including without a fixed address; or

(b) the individual's parent or caretaker, with whom the individual resides, resides in the service area of the Exchange.

B. For individuals not described in A, an individual will be considered a resident of the Exchange service area if the individual meets the state residency requirements set forth in COMAR 10.09.24.05-03.

C. Generally, if members of the tax household are not residents of the same Exchange service area, the tax household may indicate its residency as any Exchange for which one of the tax filers meets the residency standard.

D. If both spouses in a tax household enroll in a QHP through the same Exchange, a tax dependent may only enroll in a QHP through that Exchange, or through the Exchange that services the area in which the dependent meets the residency standard.

E. The Exchange shall 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 and intends to return when the purpose of the absence has been accomplished.

F. The service area of the Exchange is the state of Maryland.

.07 Eligibility Requirements for Advance Payments of the Premium Tax Credit.

A. A tax filer is eligible for advance payments of the premium tax credit if:

(1) The tax filer attests to a household income, as defined in 26 CFR §1.36B-1(e), greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(2) One or more applicants for whom the tax filer attests to claiming a personal exemption deduction on his or her federal tax return for the benefit year:

(a) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in Regulation .03 of this chapter; and

(b) Is not eligible for minimum essential coverage, with the exception of coverage in the individual market.

B. A qualified individual or, if applicable, his or her dependent, is not eligible for advance payments of the premium tax credit under this regulation until his or her coverage in an employer-sponsored plan, that is no longer a qualifying eligible employer-sponsored plan or never met the requirements of a qualifying eligible employer-sponsored plan, is terminated.

C. A non-citizen tax filer who is lawfully present and ineligible for Medicaid or MCHP by reason of immigration status, and is not otherwise eligible for APTC shall be eligible for APTC if:

(1) The tax filer meets the requirements specified in §A of this regulation, except for §A(1); and

(2) The tax filer attests to household income of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(3) One or more applicants for whom the tax filer attests to claiming a personal exemption deduction on his or her tax return for the benefit year is a non-citizen who is lawfully present and ineligible for medical assistance by reason of immigration status.

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.

E. If one or more advance payments of the premium tax credit are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan, then the advance payment shall be allocated as follows:

(1) That portion of the advance payment of the premium tax credit that is less than or equal to the aggregate adjusted monthly premiums, as defined in 26 CFR §1.36B-3(e), for the QHPs properly allocated to essential health benefits must be allocated among the QHPs according to the premium level appropriate for each individual's age-rating band premium without regard to geographic rating; and

(2) Any remaining advance payment of the premium tax credit may be allocated to the essential health benefit portion of any stand-alone dental policies.

F. A tax filer is not eligible for advance payments of the premium tax credit if:

(1) HHS notifies the Exchange that advance payments of the premium tax credit were made on behalf of the tax filer (or either spouse if the tax filer is a married couple) for a

year for which tax data would be utilized for verification of household income and family size in accordance with 45 CFR §155.320(c)(1)(i); and

(2) The tax filer or spouse did not comply with the requirement to file an income tax return for that year and reconcile the advance payments of the premium tax credit for that period.

G. Advance payments of the premium tax credit shall be calculated in accordance with 26 CFR §1.36B-3.

H. The tax filer shall attest to the following to receive advance payments of the premium tax credit:

(1) That no other taxpayer will be able to claim the tax filer as a tax dependent for the benefit year; and

(2) That the tax filer will claim a personal exemption deduction on the income tax return for the applicants identified as members of the tax filer's family, including the tax filer, who:

(a) Meet the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in Regulation .04 of this chapter; and

(b) Are not eligible for minimum essential coverage.

I. An enrollee may accept less than the full amount of advance payments of the premium tax credit for which the enrollee is determined eligible.

J. Changes in eligibility for advance payments of the premium tax credit and cost sharing reductions that are due to terminations of some or all of the enrolled household members will be effective on:

(1) the first day of the following month, for changes in eligibility determined by the Exchange between the first and the fifteenth day of a month; and

(2) the first day of the second following month, for changes in eligibility determined by the Exchange between the sixteenth and the last day of a month; or

(3) The date of the birth, adoption, placement for adoption, placement in foster care or effective date of the court order for determinations under Regulation .12(A)(2) through (7) of this chapter;

(4) The first day of the following month after the date that the Exchange receives the qualified health plan selection from the qualified individual for determinations under Regulation .12(A)(1) of this chapter; or

(5) The date specified by the Exchange for determinations under Regulation .14, .15, or .16 of this chapter.

K. When an enrollee is newly eligible for Medicaid or MCHP and terminates the enrollee's coverage in a qualified health plan, the enrollee will no longer be eligible for the premium tax credit and cost sharing reductions beginning the first of the month after the enrollee is newly eligible for Medicaid or MCHP.

L. Eligibility under this regulation is contingent on verification of the information contained in the applicant's attestations.

.08 Eligibility Requirements for Cost-Sharing Reductions.

A. An applicant is eligible for cost-sharing reductions if the applicant:

(1) Meets the requirements for eligibility for enrollment in a QHP through the Exchange pursuant to regulation .04 of this chapter;

(2) Meets the requirements for advance payments of the premium tax credit pursuant to regulation .07 of this chapter; and

(3)Except as provided under E of this regulation, attests to household income that does not exceed 250 percent of the FPL, for the benefit year for which coverage is requested.

B. An applicant is eligible for:

(1) A CSR plan for up to 150% FPL for an individual who attests to household income greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested, or for an individual who is eligible for advance payments of the premium tax credit under paragraph .07(B) of this chapter, a household income less than 100 percent of the FPL for the benefit year for which coverage is requested;

(2) A CSR plan for 151-200% FPL for an individual attests to 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;

(3) A CSR plan for 201-250% FPL for an individual who attests to 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; or

(4) Except as provided under §E of this regulation, no CSR plan for an individual who attests to household income greater than 250% for the FPL for the benefit year for which coverage is requested.

C. To the extent that an enrollment in a QHP under a single policy covers two or more individuals who, if they were to enroll in separate individual policies would be eligible

for different CSR plans, the individuals under such policy are collectively eligible only for the category of eligibility last listed below for which all the individuals covered by the policy would be eligible:

(1) Individuals not eligible for changes to cost sharing;

(2) Individuals described in §E(2) of this regulation (the special cost-sharing rule for Indians regardless of income);

(3) Individuals described in §B(3) of this regulation;

(4) Individuals described in §B(2) of this regulation;

(5) Individuals described in §B(1) of this regulation; and

(6) Individuals described in §E(1) of this regulation (the cost-sharing rule for Indians with household incomes under 300 percent of the FPL).

D. To receive cost-sharing reductions, an applicant who is not an Indian shall enroll in a silver-level QHP.

E. Special cost sharing rules for Indians.

(1) An applicant who is an Indian is eligible for zero cost sharing in a plan, if the applicant:

(a) Meets the requirements for eligibility for enrollment in a QHP through the Exchange pursuant to Regulation .04 of this chapter;

(b) Meets the requirements for advance payments of the premium tax credit pursuant to Regulation .07 of this chapter; and

(c) Attests to household income, as defined in 26 CFR §1.36B-1(e) that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(2) An applicant who is an Indian and is enrolled in a qualified health plan shall owe no cost-sharing under the plan for items or services furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

F. Eligibility under this regulation is contingent upon verification of the information contained in the applicant's attestations.

.09 Eligibility Requirements for Enrollment in a Catastrophic Plan.

A. An applicant is eligible for enrollment through the Exchange in a QHP that is a catastrophic plan if the applicant has met the requirements for eligibility for enrollment in a QHP through the Exchange, in accordance with Regulation .04 of this chapter, and either has:

(1) not attained the age of 30 before the beginning of the plan year; or

(2) a certification in effect for any plan year that he or she is exempt from the requirement to maintain minimum essential coverage under section 5000A of the Internal Revenue Code by reason of:

(a) Section 5000A(e)(1) of the Internal Revenue Code (relating to individuals without affordable coverage); or

(b) Section 5000A(e)(5) of the Internal Revenue Code (relating to individuals with hardships).

B. Eligibility under this regulation is contingent upon verification of the information contained in the applicant's attestations.

.10 Enrollment in a QHP or Catastrophic Plan

A. A qualified individual may enroll in a QHP, APTC, cost-sharing reductions or catastrophic plan or an enrollee may enroll in a different QHP or catastrophic plan only:

(1) during the annual open enrollment period, or

(2) in a special enrollment period for which the qualified individual has been determined eligible.

B. The annual open enrollment period shall occur:

(1) For the benefit year beginning on January 1, 2016, the annual open enrollment period begins on November 1, 2015 and extends through January 31, 2016.

(2) For the benefit year beginning on January 1, 2017, the annual open enrollment period begins on November 1, 2016 and extends through January 31, 2017.

(3) The annual open enrollment period shall follow any amendments to 45 CFR 155.410.

C. Coverage selected during an open enrollment period shall be effective on.

(1) For the benefit year beginning on January 1, 2016:

(a) January 1, 2016, for QHP selections received by the Exchange on or before December 15, 2015.

(b) February 1, 2016, for QHP selections received by the Exchange from December 16, 2015 through January 15, 2016.

(c) March 1, 2016, for QHP selections received by the Exchange from January 16, 2016 through January 31, 2016.

(2) For the benefit year beginning on January 1, 2017:

(a) January 1, 2017, for QHP selections received by the Exchange on or before December 15, 2016.

(b) February 1, 2017, for QHP selections received by the Exchange from December 16, 2016 through January 15, 2017.

(c) March 1, 2017, for QHP selections received by the Exchange from January 16, 2017 through January 31, 2017.

(3) The annual open enrollment period shall follow any amendments to 45 CFR 155.410.

D. If an individual:

(1) Qualifies to enroll in a QHP under Regulation .04 of this chapter; or

(2) Qualifies to enroll in a catastrophic plan under Regulation .09 of this chapter; and

(3) Selects a QHP or catastrophic plan under §A of this regulation, the Exchange shall:

(a) Notify the carrier of the applicant's selected QHP or catastrophic plan; and

(b) Transmit information necessary to enable the QHP carrier to enroll the applicant, including:

(i) an applicant’s eligibility for advance payments of the premium tax credit or cost sharing reductions, or that such eligibility for such programs has changed;

(ii) whether the carrier should implement, discontinue implementation, or modify the level of the premium tax credit or cost-sharing reductions;

(iii) The dollar amount of the advance payment of premium tax credits, if any; and

(iv) The cost-sharing reductions eligibility category.

E. The individual shall pay the first month's premium to the carrier of the QHP or catastrophic plan to effectuate enrollment in the plan when:

(1) the individual has elected a new plan after a break in enrollment; and

(2) the individual has enrolled for the first time in a plan in the Exchange.

F. The Exchange shall maintain records of all enrollments through the Exchange.

.11 Special Enrollment Periods—Loss of Minimum Essential Coverage

A. A qualified individual or enrollee, and, when specified in this regulation, his or her dependent, is eligible for a special enrollment period for loss of minimum essential coverage if:

(1) A qualified individual or the dependent of a qualified individual loses eligibility for employer-sponsored coverage that is not COBRA continuation coverage for reasons including:

(a) legal separation;

(b) divorce;

(c) cessation of dependent status;

(d) death of an employee;

(e) termination of employment;

(f) reduction in the number of hours of employment;

(g) coverage does not provide benefits to individuals who no longer reside, live, or work in a service area and the individual no longer resides, lives, or works in the service area;

(h) an individual incurs a claim that would meet or exceed a lifetime limit on all benefits;

(i) the individual's plan no longer offers any benefits to the class of similarly situated individuals that includes the individual;

(j) the employer terminates employer contributions to coverage; or

(k) a qualified individual or dependent, who is enrolled in an employer-sponsored plan, is determined newly eligible for APTC because the employer-sponsored plan is no longer considered minimum essential coverage under 26 CFR §1.36B-2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, if the qualified individual or qualified individual's dependent is permitted by the employer and applicable federal laws to terminate enrollment in the employer-sponsored plan.

(2) A qualified individual or the dependent of a qualified individual loses eligibility for employer-sponsored coverage that is COBRA continuation coverage because the individual exhausted COBRA continuation coverage;

(3) A qualified individual or the dependent of a qualified individual was enrolled in coverage through non-calendar year group health plan or individual health insurance coverage and the coverage has ended, even if the qualified individual or his or her dependent has the option to renew such coverage;

(4) A qualified individual or the dependent of a qualified individual loses pregnancy-related coverage described in COMAR 10.09.24.03A(2);

(5) A qualified individual or the dependent of a qualified individual loses the medically needy coverage described in COMAR 10.09.24.03E; or

(6) An enrollee or an enrollee's dependent loses coverage in a qualified health plan because the qualified health plan is decertified.

B. Loss of minimum essential coverage does not include termination or loss due to:

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage;

(2) A change in eligibility status under 45 CFR §155.315(f)(5) because the individual does not meet the requirement specified at Regulation .04(A(1); or

(3) a carrier's valid rescission of coverage.

C. The date of loss of minimum essential coverage is the date the qualified individual or his or her dependent loses eligibility for minimum essential coverage under his or her previous plan.

D. To be eligible for a special enrollment period under this regulation, a qualified individual must report the loss of minimum essential coverage and, if the qualified individual or his or her dependent chooses to select a plan, selects a plan in the time period between 60 days before the loss of minimum essential coverage and 60 days after the loss of minimum essential coverage.

E. Qualified health plan coverage selected by a qualified individual or, as applicable, his or her dependent during a special enrollment period for loss of minimum essential coverage will be effective on the:

(1) first day of the following month following the loss of minimum essential coverage if the Exchange receives the qualified health plan selection from the qualified individual or, as applicable, his or her dependent prior to the loss of minimum essential coverage; or

(2) first day of the month after the Exchange receives the qualified health plan selection from the qualified individual or, as applicable his or her dependent, if the

Exchange receives the qualified health plan selection from the qualified individual or, as applicable his or her dependent after the loss of minimum essential coverage.

F. The eligibility for special enrollment period described in §A(6) of this regulation is only available once per calendar year.

.12 Special Enrollment Periods—Change in Family Status

A. A qualified individual and a qualified individual's dependent are eligible for a special enrollment period for change in family status if the qualified individual gains a dependent or becomes a dependent through:

(1) marriage;

(2) birth;

(3) adoption;

(4) placement for adoption;

(5) placement in foster care;

(6) a child support order; or

(7) other court order.

B. Effective on January 1, 2017, a qualified individual and a qualified individual's dependent are eligible for a special enrollment period for change in family status if the qualified individual loses a dependent or is no longer considered a dependent through:

(1) divorce;

(2) legal separation; or

(3) death.

C. Family status changes will be determined in accordance with the law of the state where the change in family status occurred.

D. If eligible for a special enrollment period under this regulation, a qualified individual or the qualified individual's dependent shall select a plan within 60 days of the change in family status under §A and §B of this regulation.

E. Qualified health plan coverage selected by a qualified individual or his or her dependent during a special enrollment period under this regulation will be effective on:

(1) For marriages, formation of civil partnerships, divorces, and dissolution of civil partnerships, the first day of the following month after the date that the Exchange receives the qualified health plan selection from the qualified individual.

(2) In the case of birth, adoption, placement for adoption, placement in foster care, or court order, on the date of birth, adoption, placement for adoption, placement in foster care or effective date of court order.

(3) In the case of death, the first day of the following month after the date that the Exchange receives the qualified health plan selection from the qualified individual.

.13 Special Enrollment Period – Error, Misrepresentation, or Inaction.

A. As evaluated and determined by the Exchange, a qualified individual or dependent is eligible for a special enrollment period due to error:

(1) when the individual or dependent's enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous; and

(2) is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or its instrumentalities.

B. The qualified individual or qualified individual's dependent shall notify the Exchange of the alleged error, misrepresentation, or inaction:

(1) Within 10 days of the alleged error, misrepresentation, or inaction; or

(2) within 10 days of when the qualified individual reasonably should have known about the alleged error, misrepresentation or inaction.

C. The length of the SEP shall be 60 days from the date that the Exchange notifies the qualified individual that the qualified individual or the qualified individual's dependent is eligible for an SEP under this regulation.

D. If the Exchange determines that a qualified individual or dependent is eligible for a special enrollment period under this regulation, the Exchange shall determine, based on the circumstances, the appropriate effective date of the qualified health plan coverage, if selected by a qualified individual or his or her dependent during the special enrollment period under this regulation.

(1) The effective date shall be no earlier than the date that the qualified individual or qualified individual's dependent's coverage would have begun but for the error, misrepresentation, or inaction.

(2) Depending on the nature of the error, misrepresentation, or inaction, the effective date may be retroactive.

.14 Special Enrollment Period – Violation of Material Provision or Misconduct.

A. An enrollee or dependent is eligible for a special enrollment period if the enrollee or dependent demonstrates, as determined by the Exchange in collaboration and coordination with the Maryland Insurance Administration:

(1) That the qualified health plan in which the enrollee or dependent is enrolled substantially violated a material provision of its contract in relation to the enrollee or his or her dependent; and

(2) The enrollee, or dependent, notifies the Exchange or the Maryland Insurance Administration of the alleged violation:

(a) Within 10 days of the violation; or

(b) Within 10 days of when the qualified individual reasonably should have known about the violation.

B. A qualified individual, enrollee, or dependent is eligible for a special enrollment period if the Exchange determines, in collaboration and coordination with the Maryland Insurance Administration:

(1) That, as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities, a qualified individual, enrollee, or dependent was:

(a) not enrolled in qualified health plan coverage;

(b) was not enrolled in the qualified health plan selected by the qualified individual or enrollee; or

(c) is eligible for but is not receiving advance payments of the premium tax credit or cost-sharing reductions; and

(2) The qualified individual, enrollee, or dependent alleging misconduct notifies the Exchange or the Maryland Insurance Administration of the alleged misconduct:

(a) Within 10 days of the misconduct, or

(b) Within 10 days of when the qualified individual reasonably should have known about the misconduct.

C. The length of the SEP shall be 60 days from the date that the Exchange notifies the qualified individual that the qualified individual or the qualified individual's dependent is eligible for an SEP under this regulation.

D. For any circumstance described in this regulation, the effective date of the qualified health plan coverage selected by a qualified individual or a dependent will be an appropriate date based on the circumstances, as determined by the Exchange, in collaboration and coordination with the Maryland Insurance Administration, when appropriate.

(1) The effective date shall be no earlier than the date that the qualified individual or qualified individual's dependent's coverage would have begun but for the error, misrepresentation, or inaction.

(2) Depending on the nature of the error, misrepresentation, or inaction, the effective date may be retroactive.

.15 Special Enrollment Period—Exceptional Circumstances.

A. A qualified individual, enrollee, or dependent is eligible for a special enrollment period if the qualified individual, enrollee, or dependent, if, upon application the Exchange, the Exchange finds, in its sole discretion, that the individual meets other exceptional circumstances that prevented the individual or dependent from enrolling during open enrollment, except an individual may qualify under §C(2) and (3) of this regulation at any time during the calendar year.

B. The qualified individual or qualified individual's dependent shall notify the Exchange of the exceptional circumstances within 10 days of the exceptional circumstances.

C. Exceptional circumstances may include, but are not limited to:

(1) A serious medical condition like an unexpected hospitalization or temporary cognitive disability;

(2) Experiencing domestic abuse or violence;

(3) Spousal abandonment; or

(4) Natural disaster, such as an earthquake, massive flooding, or hurricane.

D. The length of the SEP shall be 60 days from the date that the Exchange notifies the qualified individual that the qualified individual or the qualified individual's dependent is eligible for an SEP under this regulation.

E. If the Exchange determines that a qualified individual or dependent is eligible for a special enrollment period under this regulation, the Exchange shall determine, based on the circumstances, the appropriate effective date of the qualified health plan coverage, if selected by a qualified individual or his or her dependent during the special enrollment period under this regulation.

(1) The effective date shall be no earlier than the date that the qualified individual or qualified individual's dependent's coverage would have begun but for the exceptional circumstance.

(2) Depending on the nature of the exceptional circumstance, the effective date may be retroactive.

.16 Special Enrollment Period—Permanent Move.

A. A qualified individual, enrollee or dependent is eligible for a special enrollment period if the qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move.

(1) A permanent move includes leaving a jail or prison upon release from incarceration.

(2) A permanent move does not include a short-term or temporary move where the individual or enrollee, or his or her dependent, does not intend to remain in the individual's new location.

B. A qualified individual or enrollee, or his or her dependent, has 60 days from the date of the permanent move to notify the Exchange of the move and select a qualified health plan.

C. In addition to B of this regulation, effective January 1, 2017, a qualified individual or enrollee, or his or her dependent, has 60 days before the permanent move to notify the Exchange of the move and select a qualified health plan.

D. Qualified health plan coverage selected by a qualified individual or, as applicable, his or her dependent during a special enrollment period under this regulation will be effective:

(1) Prior to January 1, 2017, either:

(a) the first day of the following month, for qualified health plan selections received by the Exchange between the first and the fifteenth day of a month; and

(b) the first day of the second following month, for qualified health plan selections received by the Exchange between the sixteenth and the last day of a month; or

(2) Effective January 1, 2017, the first day of the following month following the move if the Exchange receives the qualified health plan selection from the qualified individual or, as applicable, his or her dependent prior to the permanent move.

.17 Special Enrollment Period—Other.

A. A qualified individual, enrollee, or dependent is eligible for a special enrollment period if:

(1) the enrollee or dependent is determined newly eligible or ineligible for APTC, or has a change in eligibility for cost-sharing reductions;

(2) the qualified individual who is an Indian chooses to enroll in a qualified health plan or change from one qualified health plan to another, up to one time per month; or

(3) the qualified individual, enrollee, or dependent who was not previously a citizen, national, or lawfully present gains such status.

B. A qualified individual or enrollee, or where applicable his or her dependent, has 60 days from the date of the change in circumstance creating eligibility for a special enrollment period under §A of this regulation to notify the Exchange of the change in circumstance and select a qualified health plan.

C. A qualified health plan selection received by the Exchange from a qualified individual eligible for a special enrollment period under this regulation is effective:

(1) the first day of the following month, for qualified health plan selections received by the Exchange between the first and the fifteenth day of a month; and

(2) the first day of the second following month, for qualified health plan selections received by the Exchange between the sixteenth and the last day of a month.

.18 Exemptions.

A. Under 45 CFR §155.625(b), the Exchange has delegated administration of all exemption determinations for Maryland residents to HHS.

B. An applicant shall follow:

(1) The procedures specified by HHS to apply for an exemption under Subpart G of Part 155, Title of Public Welfare; and

(2) The procedures specified by the Internal Revenue Service to apply for an exemption under 26 CFR §1.5000A-3.

.19 Authorized Representative.

As specified in 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 person or 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.