MARYLAND HEALTH BENEFIT EXCHANGE RESPONSES TO INFORMAL PUBLIC COMMENTS ON PROPOSED COMAR 14.35.14 (version 1)

The following chart summarizes informal public comments submitted to Maryland Health Benefit Exchange (MHBE) by April 27, 2016 regarding proposed COMAR 14.35.14 and MHBE's response to each comment. Comments are organized by regulation (identified in the Source Comment column) and the commenting individual and/or organization is listed in the "Source" column (please refer to Source Key below for abbreviations guidance). Accepted comments are incorporated into the revised and redlined version two of proposed COMAR 14.35.14, which is also being shared at this time. MHBE will address these comments at the May 12, 2016 public meeting. Revisions to COMAR 14.35.01.02 (Definitions) (version 3) - which has been updated to include comments pertaining to definitions addressed in Chapter 14 and general definition comments - is also being shared at this time. Further revisions to COMAR 14.35.01.02 that address comments received for definitions covered in proposed COMAR 14.35.15-.17 will be addressed as MHBE's shares revised and redlined versions of proposed COMAR 14.35.15-.17.

Additional written comments may be submitted to MHBE regarding proposed COMAR 14.35.14 version 2 by May 23, 2016 at mhbe.policy@maryland.gov.

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

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

Source	Comment	MHBE Response
		federal requirements in state regulations for additional information about this approach, which may be found here: http://www.marylandhbe.com/policy-legislation/public-comment/.
Carefirst	**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 fact, in proposed COMAR 31.10.01.02 (B)(5) specifically indicates	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. 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. 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. MHBE proposes to work with carriers to establish an automated process that would allow the carrier to send the termination request for an

Source	Comment	MHBE Response
	that the policyholder is the person to whom the carrier's contract is issued. 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. 31.10.0l.03(S) and 31.10.13.13 (changes of premium to the policy- holder only, MD. CODE REGS. 31.10.0l.03(S) and 31.10.28.05 (policyholder determines premium payment mechanism).	individual in a household to MHBE, MHBE would then redetermine the eligibility of the remaining members and provide the appropriate 834 back to the carrier to continue the contract but the individual requested termination is no longer enrolled. In addition, MHBE has added proposed text to address questions raised about the status of the policyholder in individual termination requests where the enrollee requesting the termination is the policyholder. MHBE proposes that for 2017, a carrier either: 1) continue the contract with the original policyholder who moves to the position of responsible adult in lieu of an enrollee, 2) allow the original policyholder to assign the contract to another enrollee who is maintaining their enrollment or 3) if the carrier cannot currently accomplish items 1 or 2, then manually apply the household accumulators from the original contract to the new contract with the household members who have maintained coverage. MHBE proposes for 2018 that the carrier use approach 1 or 2. It is MHBE's understanding that these proposals do not contradict State law requirements. However, MHBE has proposed an effective date of 1/1/18 to implement one of the approaches in order to allow carriers to build this approach into the 2018 forms filed with MIA. In addition, it is MHBE's understanding that carriers have expressed support for continuing household accumulators when the primary enrollee is no longer enrolled in coverage based on a voluntary termination, such as due to new Medicare eligibility. Further, it is MHBE's understanding that carriers currently will manually move accumulators for some households that request this action after the primary is terminated.
Carefirst	**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.	As noted in the rule, MHBE will specify a format for the records under 45 CFR 155.430(c)(1).

Source	Comment	MHBE Response
Carefirst	**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 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	MHBE believes this comment pertains to F. 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. Please refer to comments above pertaining to the termination process for requests made to the carrier.

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	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.	
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.	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. 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.
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.	Please refer to comments above regarding voluntary terminations.

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	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 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.	
Chris Keen	**14.35.14.04(A) -** [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.
MIA	**14.35.14.04(A) -** The word “select” should be substituted for the “direct” in the second line.	Edit incorporated.

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HEAU	**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.	Incorporated within newly proposed B.
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."

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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.
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).

Source	Comment	MHBE Response
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?	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). SHOP rules will be included in a separate chapter at a later date.
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.	The proposed rule allows the carrier to terminate for non-payment (there is no request from the consumer required) (see .07(A)). Reasons included under .07 mirror 45 CFR 155.430(b)(2) that would not require the Exchange to initiate the termination. Please refer to comments above regarding voluntary termination requests.
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.
MIA, HEAU	**14.35.14.06(B)(1) -** This item is dealing with when a carrier may terminate coverage for nonpayment of premium. a. It would seem that item (a) should be deleted, as it is incomplete. It does not discuss the grace period. b. It would appear that this item should be revised to describe the two different grace periods—the one that applies if the	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.

Source	Comment	MHBE Response
	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. 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.	
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…"
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.

Source	Comment	MHBE Response
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).
MIA	**14.35.14.06(C) - T**he 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	Edits incorporated to include 147.106(b)(2) reasons.

Source	Comment	MHBE Response
	may be cancelled for fraud or for intentional misrepresentation of material fact. See 45 CFR § 147.106(b)(2).	
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.
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	References incorporated for COMAR 31.10.25.04C (for nonprofit health services plans) and COMAR 31.12.07.05D (for HMOs).

Source	Comment	MHBE Response
	appear in the contract permitting the individual to ask to be reinstated. The carrier can say "no."	
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 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.	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 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) (l)(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.

Source	Comment	MHBE Response
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.