MARYLAND HEALTH BENEFIT EXCHANGE RESPONSES TO INFORMAL PUBLIC COMMENTS ON PROPOSED COMAR 14.35.16 (version 1)

The following chart summarizes informal public comments submitted to Maryland Health Benefit Exchange (MHBE) by April 27, 2016 regarding proposed COMAR 14.35.16 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 14.35.16, which is also being shared at this time. MHBE will address these comments at the June 14, 2016 public meeting.

Additional written comments may be submitted to MHBE regarding proposed COMAR 14.35.16 version 2 by June 7, 2016 at mhbe.policy@maryland.gov if the interested party wishes to comment in writing prior to the meeting. Written comments will also be accepted after the meeting until June 24, 2016.

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
The League	**14.35.16** requires duplicative data reporting of information already reported to MHCC	The data reporting requirements contained in 14.35.16 are necessary for the Exchange to carry out the core function of plan certification. The requirements have been amended to minimize duplication with other carrier reporting requirements.

Source	Comment	MHBE Response
MIA	**COMAR 14.35.16.02.(B)(1):** "Commission" should be replaced with "Commissioner."	Definition removed, incorporated into definitions in COMAR 14.35.01.02.
MIA	**COMAR 14.35.16.02(B)(3):** The term "similarly-situated" is used for the first time in subsection (3), and it is not defined in Chapter 16, or in the proposed draft for the general definitions section of COMAR 14.35.01.02.	Suggestion not incorporated at this time. The term "similarly-situated" is meant to be flexible and therefore will not be defined specifically in this regulation.
MIA	**COMAR 14.35.16.03(A):** The term "SHOP plan" is used, which is not defined in Chapter 16, or in the proposed draft for the general definitions section of COMAR 14.35. 01.02. However, it appears the reference to this term is unnecessary, since §A already mentions qualified health plans and dental plans offered in the SHOP Exchange.	Suggestion incorporated.
MIA	**COMAR 14.35.16.03(B):** The term "authorized plan" is used for the first time in §B, and it is not defined in Chapter 16, or in the proposed draft for the general definitions section of COMAR 14.35.01.02.	Suggestion incorporated, term removed.
MIA	**COMAR 14.35.16.03(B):** It seems that §B should be split into two different sections, one addressing the Individual Exchange, and the other addressing the SHOP Exchange. It would be possible for a carrier to lose certification to participate in one Exchange but still have certification to participate in the other Exchange. It would also be possible for a carrier to withdraw from either the individual or small group market, while continuing to offer plans in the other market. The current text of the regulation does not contemplate these types of situations.	Suggestion not incorporated at this time. This section does not apply to carrier certification for either the Individual or SHOP Exchange and also does not apply to the certification of qualified plans offered in the SHOP Exchange.
MIA	**COMAR 14.35.16.03(B)(3):** The text refers to a situation where a carrier "withdraws the plan from the market under 45 CFR §156.290." However, the federal regulation that is cited discusses situations where a carrier fails to seek recertification with the Exchange, or a plan is decertified by the Exchange. This is not the same thing as withdrawal from the market. It would be possible for a particular plan to no longer be offered through the Exchange, but still be permitted to be sold outside of the Exchange.	Suggestion incorporated.

Source	Comment	MHBE Response
MIA	**COMAR 14.35.16.03(C):** The language of §C is unclear. First, a "plan" would not set the premium rating structure. Rather, the "carrier" would set the premium rating structure for the plan. Language such as the following would be preferable: "A carrier shall cap the premium rating for dependents at three dependents under the age of 21 for all plans authorized under this Chapter for sale in the Exchange." Second, it is unclear whether rating factors for spouses are intended to be included in this premium rating cap. A spouse is classified as a "dependent," but most spouses would not be under the age of 21. This issue requires clarification.	Suggestion incorporated. Regulation .03(C) is amended to mirror the federal regulation at 45 CFR 147.102(c)(1).
MIA	**COMAR 14.35.16.04:** We assume this regulation is intended to set forth the application requirements for qualified health plans and qualified dental plans. However, many of the requirements would only seem appropriate for a qualified health plan. It seems separate requirements should be listed for qualified dental plans.	Suggestion not incorporated at this time. Application requirements for dental plans seeking certification as stand-alone dental plans will be addressed in a separate chapter of the regulations.
MIA	**COMAR 14.35.16.04(A):** The reference to "qualified health plan" appears problematic because at the time the application for the plan is submitted to the Exchange, it is not a "qualified" plan, as it has not yet been certified by the Exchange. We suggest revising §A as follows: "Each authorized carrier shall annually submit an application form specified by the Exchange for each health plan intended to be certified as a qualified health plan." Note that we also moved the phrase "specified by the Exchange" for clarity.	Edit incorporated.
Carefirst	**14.35.16.04(B)** requires carriers to submit applications for each QHP no later than July 1. If the MIA has not yet approved that QHP, it is unclear why the carrier should submit that information to the Exchange by July 1. This date should be modified to reflect that the carrier should submit the information once approved by the MIA.	Edit incorporated to reflect that carrier should submit QHP promptly and without undue delay after MIA approves the QHP.
MIA	**COMAR 14.35.16.04(C):** In §C, the Exchange imposes a requirement on itself, but the regulation does not explain what happens if the Exchange does not fulfill its obligation. It is very unusual for a regulator to place a requirement on itself in regulations that the regulator will be enforcing. However, if the intention is to retain this requirement, the regulations should be amended to indicate what will happen if the Exchange misses its self- imposed deadline. For example, would the application	Suggestion not incorporated at this time. The requirement that the Exchange notify a carrier of the decision to approve or deny a carrier's application for plan certification is intended to give notice of the expected timeline for the Exchange's response, based upon previous agreements under the interim procedures

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	be deemed approved in this situation? Additionally, the text refers to receipt of a "completed application." What happens if the application is incomplete?	(http://www.marylandhbe.com/wp-content/uploads/2013/05/MHBE-QHP-Interim-10-23-20121.pdf).
MIA	**COMAR 14.35.16.04(D):** §D begins with the text "when necessary," but does not explain the conditions that determine whether it is necessary to provide an initial and final data submission.	Suggestion incorporated, "when necessary" removed.
Carefirst	**COMAR 14.35.16.04(E)** appears to repeat governing federal law. This will create discrepancies between the governing federal law and Exchange regulations when the federal government modifies or reinterprets the regulations in the future. The Exchange should not, and does not need to, codify federal regulations into State law for them to apply to Exchange operations. Moreover, even if the Exchange still feels it necessary to reiterate federal or State insurance law in Exchange regulation, the draft regulations do not mirror the language of existing federal or Maryland insurance law. Rather, the draft regulations only summarize or paraphrase portions of the highly complex applicable law. This is likely to cause unnecessary conflicting application of the governing laws and significant confusion for all stakeholders. See 45 CFR § 156.220.	Suggestion incorporated. Regulation .04 has been amended to mirror the language of 45 CFR 156.220 and Insurance Article 31-115(g).
MIA	**14.35.16.04(E)(2):** The requirement in subsection (2) to provide "information on implementation of enrollee rights under title I of the Affordable Care Act" seems very vague. It is unclear which particular "enrollee rights" are being referenced, and is it unclear what particular information about those rights is required.	Suggestion not incorporated at this time. The requirement that authorized carriers provide Information on enrollee and participant rights under Title I of the Affordable Care Act mirrors the language of 45 CFR 156.220 and Insurance Article 31-115(g).
Carefirst	**14.35.16.04(F)** - is repeated, the second one should be renumbered.	Suggestion incorporated.
MIA	**14.35.16.04(F):** It is unclear how the requirements of §F interact with §31- 115 of the Insurance Article. Are the items described in the regulation intended to flesh out the requirements of §31-115, or are they intended to be in addition to the requirements of the law?	Regulation .04(F) reflects both federal and state requirements for carrier information disclosures and has been amended to include documentation and information

Source	Comment	MHBE Response
		carriers are required to provide as part of the plan certification process.
Carefirst	**14.35.16.04(F)(4) and (6)** require a carrier to provide the average drive time to PCPs and mental health providers in the plan's network and .04(F)(3) and (5) require a carrier to provide the average drive distance to these providers. It is unclear how a carrier could ever accomplish providing this information - from where does a carrier calculate the drive distance? From the carrier's headquarters? Also, which route, on which days, and at which times of day does the carrier calculate the drive time? These regulations should be removed until further discussion about them has occurred. CMS proposed time/ distance standards in its 2017 NBPP but opted against including them in the final notice. CMS stated the reason for this was to allow more time to adopt NAIC model act standards that were recently finalized. The Exchange is therefore proposing standards here that CMS has indicated are premature at this time. In addition, CareFirst remains concerned that requiring standards for only MBHE plans and not off-exchange plans will result in significant adverse selection and skew the market. If any network adequacy standards are to be created in Maryland, they should be consistent and market wide. This can only be accomplished by the MIA proposing statutory or regulatory changes that would apply to both the on- and off-exchange markets. This position was affirmed through House Bill 1318.	MHBE provided this template that mirrors the FFM's proposed definitions of these terms. The proposed provisions have been updated to allow for further specification through Exchange guidance. This information will be shared publicly to assist with consumer review of plans and will not be used as a standard of network adequacy. MHBE staff will ask the Board whether it wishes to include the network metrics within the regulations at this time. Please find the guidance here: http://www.marylandhbe.com/wp-content/uploads/2016/03/FINAL-Operational-Guidance-----Network-Adequacy-Metrics-Template.pdf.
MIA	**14.35.16.04(F)(10):** In subsection (10), the reference to "paragraph E" appears incorrect. There is no "paragraph" E, and §E does not address provider directory data.	Suggestion incorporated.
MIA	**14.35.16.04(F)(12):** In subsection (12), the terms "summaries of benefits and coverage" and "plan variation" are used for the first time, and are not defined in Chapter 16, or in the proposed draft for the general definitions section (14.35. 01.02.)	Suggestion incorporated. "Plan variation" is defined at 14.35.01.02" and the requirement that carriers provide "summaries of benefits and coverage" has been edited to cross-reference 45 CFR §147.200.
Carefirst	**14.35.16.05(D)** requires carriers to provide the final disposition of premium rate increases before the premium's effective date. This presumes that a carrier continues offering a QHP in a subsequent year and seeks rate increases for the QHP. This is not always the case. The regulation should be modified to reflect that such information is	Suggestion incorporated.

Source	Comment	MHBE Response
	only necessary if the QHP application the carrier submits is for the same QHP submitted in a previous year and the carrier increased the rates for such QHP.	
MIA	**14.35.16.05(D):** §D includes the odd language "the premium rate increase request by the Commissioner." The Commissioner does not request rate increases from the carriers. The carrier requests a rate increase, and then the Commissioner reviews the request and determines whether to approve or deny the rate increase.	Suggestion incorporated.
The League	**14.35.16.06** (Plan Service Areas) is troubling. This proposal requires demographic reporting. It is not clear if the reporting is specific to the service area generally or the plan's member population specifically. The requirement also includes a number of elements that would be hard to ascertain with regard to members. Many carriers do have complete race or ethnicity data as members are not required to provide it. In addition, carrier's may not have language information, info. on disabilities or genetic info. (the collection of which is prohibited by Federal law, specifically the Genetic Information Non- discrimination Act (GINA)). Further, the reporting on treatment costs is duplicative of information reported to MHCC.	MHBE proposes an alternate method for meeting requirement to evaluate plan service areas for impermissible use of factors. MHBE will couple plan-submitted information with other available information sources.
MIA	**14.35.16.06(A):** The meaning and intent of §A is unclear to us. The text appears to require a carrier to use the same service area for all of the plans it offers for sale on the Exchange, and it appears that the Exchange is mandating what the service area must be. However, some carriers that offer multiple products through the Exchange use different service areas for different products. The Administration has approved forms and rates for several of these types of products over the past few years. Additionally, some carriers use different service areas in the individual and small group markets. Is the intent of §A to prohibit these differences in service areas? If so, this would be a major policy change, which would be very difficult to implement for 2017, as all the carriers have already filed their 2017 products with the Administration. If this is not the intent of §A, then the language should be clarified.	MHBE included mandates as a carryover from historic procedure. Based on feedback from MIA, this section deleted as no longer relevant.
MIA	**14.35.16.06(A)(1)(a):** The terms "commercial market service area" and "commercial health benefit plans" are used for the first time in paragraph (a), and they are not defined in Chapter 16, or in the proposed draft for the general definitions section of COMAR 14.35.01.02.	

Source	Comment	MHBE Response
MIA	**14.35.16.06(A)(1)(b):** The term "managed care organization" is used for the first time in paragraph (b), and it is not defined in Chapter 16, or in the proposed draft for the general definitions section of COMAR 14.35.01.02.	
MIA	**14.35.16.06(A)(1)(c):** Paragraph (c) does not make sense to us. It refers to situations where a carrier is "only serving a managed care organization." However, Chapter 16 applies only to plans certified by the Exchange as qualified plans. If a carrier is only operating as a managed care organization and is not participating in the commercial market, the carrier would not be offering any qualified plans in Maryland. Therefore, it seems the situation described in paragraph (c) would never occur.	
MIA	**14.35.16.06(B):** First, it appears that the cross-reference to "Regulation .04D" should be "Regulation .06D." Second, §B indicates that the MIA must approve any change in a plan's service area, but the Administration does not currently perform this function.	The reference to .04D is correct, as it refers to data submission by carriers to the Exchange. Amended the citation to "COMAR 14.35.16.04D".
MIA	**14.35.16.06(C):** It appears that the cross-reference to "Regulation .04C" is incorrect, as that regulation does not discuss final data submission.	Suggestion incorporated. Amended the citation to the appropriate regulation and section - "COMAR 14.35.16.04D".
Carefirst	**14.35.16.06(E)** It is unclear how this complies with the prohibition in HB 1318, which will create a new MD. CODE ANN., INS. §31-115(m) that will provide that: "any certification standards established under sub-section (k) of this section related to network adequacy or network directory accuracy: (1) shall be consistent with the provisions of § 15-112 of this article; and (2) may not be implemented until January 1, 2019."	This requirement is not related to network adequacy. Requirement relates to non-discriminatory service area requirement.To capture requirements under 45 CFR 155.1055, requirement changed to: .06(A)(2) For a services area smaller than statewide, an authorized carrier shall submit, for each health benefit plan not covering a statewide service area that the authorized carrier seeks to offer for sale through the Individual Exchange, an explanation of the demographics of the service areas served by the health benefit plan.
MIA	**14.35.16.06(E):** §E requires carriers to submit demographic data on a plan's service areas as part of the plan certification process. This requirement appears problematic because the carriers may not have the requested information at the time of application for plan certification, especially if the service area is new. If the data is only being requested based on the prior year for an existing service area, this should be clarified. We further question whether carriers would ever have the race,	Requirement not related to network adequacy. Requirement relates to non-discriminatory service area requirement.To capture requirements under 45 CFR 155.1055, requirement changed to: .06(A)(2) For a services area smaller than statewide, an authorized carrier shall submit, for each health benefit

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	ethnicity, language, and genetic information data requested in subsection 1), 2), 3), and 9). We are not certain if carriers collect any or all of this information. Finally, it is unclear what data regarding "evidence of insurability" is being requested. Carriers are prohibited from requiring medical evidence of insurability under health benefit plans due to the ACA.	plan not covering a statewide service area that the authorized carrier seeks to offer for sale through the Individual Exchange, an explanation of the demographics of the service areas served by the health benefit plan.
Carefirst	**14.35.16.06(E)** requires carriers to submit data on "the demographics of areas service by each qualified plan" the carriers offers on the Exchange. It is unclear what this requirement means - as this requirement is a condition of participation, the carrier has not yet sold the plans to potential Exchange members and therefore cannot know what those members' demographics are. If the purpose of the regulation is to provide information retrospectively about who the certified QHP enrollees are, the regulation should not indicate that it is a requirement of participation to provide the information. If the purpose of the regulation is to generally obtain information from carriers about the general demographics about potential enrollees in the carriers' QHP service areas, such information is not appropriately requested by the Exchange as a carrier is not obligated to and may have no reason to know the general information about its prospective enrollees in its service area. Such information would be better obtained from the US Census Bureau, which collects some of this information.	To capture requirements under 45 CFR 155.1055, requirement changed to: .06(A)(4) For a services area smaller than statewide, an authorized carrier shall submit, for each health benefit plan not covering a statewide service area that the authorized carrier seeks to offer for sale through the Individual Exchange, an explanation of the demographics of the service areas served by the health benefit plan.
Carefirst	**COMAR 14.35.16.06(E)(1)-(3)** are duplicative of a carrier's reporting obligations to the Maryland Health Care Commission and are therefore unnecessary and unduly burdensome to report to both agencies. See MD. CODE ANN., HEALTH-GENERAL § 19-134(c), MD. CODE REGS. 10.25.08.03D(l), 10.25.06.10. The Exchange Carrier Reference Manual also requires that carriers provide RELICC data to the MHCC. This also seems inconsistent with the proposed requirement in .08(B) that requires carriers to submit the same information to the MHCC.	This comment is no longer applicable under the new proposed approach. This requirement is not related to network adequacy. Requirement relates to non-discriminatory service area requirement.To capture requirements under 45 CFR 155.1055, requirement changed to: .06(A)(2) For a services area smaller than statewide, an authorized carrier shall submit, for each health benefit plan not covering a statewide service area that the authorized carrier seeks to offer for sale through the Individual Exchange, an explanation of the demographics of the service areas served by the health benefit plan.
Carefirst	**COMAR 14.35.16.06(E)(4)-(7)** are vague and unclear and should be clarified before proposed.	
Carefirst	**COMAR 14.35.16.06(E)(8) -** The reporting requirement on genetic information violates the Genetic Information Nondiscrimination Act (GINA), which prohibits carriers from collecting genetic information (including family medical history) prior to	

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	or in connection with enrollment, or for underwriting purposes. As carriers cannot collect genetic information about members, they cannot under federal law report this information to the Exchange. It is also unclear why the Exchange requests this information and what privacy protections it would place on this information to ensure individuals' genetic information is protected.	
Carefirst	No carrier can report on the reporting requirement in **14.35.16.06(E)(9),** as no individual in the insured market is uninsurable under federal and State guaranteed availability requirements. See 42 USC § 300gg-l; MD. CODE ANN. INS. §§15-137.l (a)(20), 15- 1410(b).	
Carefirst	No carrier can report on the reporting requirement in **14.35.16.06(E)(10),** as carriers cannot discriminate on members' or prospective members' disability. It is unclear how the Exchange believes that a carrier identifies or collects the disability status of its members or prospective members.	
HEAU	**14.35.16.07** - HB 1318 has new requirements that must be met. That statutory provision should be cross- referenced.	Cross reference to 15-112(n)(3) incorporated at .07(C)(3).
Carefirst	**14.35.16.07** - It is unclear how this complies with the prohibition in HB 1318, which will create a new MD. CODE ANN., INS. §31-l 15(m) that will provide that: "any certification standards established under subsection (k) of this section related to network adequacy or network directory accuracy: (1) shall be consistent with the provisions of § 15-112 of this article; and (2) may not be implemented until January 1, 2019."	Provider directory requirements do not contradict or supersede HB1318 requirements. Requirements only incorporate pre-existing federal requirements and minimal processes necessary to maintain CRISP. Requirements are unrelated to standards for accuracy and only relate to requirements for providing information for basic provider directory federal requirements. Information required in .07 is for consumer transparency and is not used as a network adequacy standard. MHBE staff will ask the Board whether it wishes to include the network metrics within the regulations at this time.
The League	**14.35.16.07(A)(1)** requires a carrier to submit its standard for network management information submitted for accreditation to either NCQA or URAC. This requirement is not consistent with the submissions made to accrediting bodies by carriers, which are not submissions of the carrier's standards.	The information submitted includes availability of practitioners, accessibility of services, member experience, continued access to care, marketplace design criteria for practitioners and hospitals, and physician and

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Carefirst	**14.35.16.07(A)(1)** requires a carrier to submit its standard for network management information submitted for accreditation to either NCQA or URAC. Carriers do not submit its standards to NCQA or URAC for accreditation. Rather, the carrier submits evidence that it meets the accreditor's standards. This provision needs to be modified to reflect how carriers and accrediting agencies interact. Also, it is unclear why MHBE needs to know what a carrier submits to an accrediting agency - that a carrier or plan is accredited should suffice.	hospital directories. Additionally the standard require the plan to evaluate access to high-volume specialty care services; assess and improve member experience with the plan's network; identify and act on opportunities to improve network adequacy and annually assess accuracy of certain physician directory information and act on opportunities to improve accuracy. Carriers don't have to meet all factors for accreditation. MHBE intends to review this information to ensure that the carrier is complying with consumer transparency provisions and federal law, as it is required to do by federal law.
MIA	**14.35.16.07(A)(2):** The treatment examples specified in subsection (2) do not appear clear or specific enough to enable carriers to provide the requested treatment cost information. More details should be provided, such as the specific CPT codes for the services included in the examples. Provider fee schedules are usually considered proprietary or trade secrets by carriers. If the intention is to develop coverage examples similar to those found in the federal Summary of Benefits and Coverage, the Exchange should consider providing the information that CMS provides to carriers, such as the diagnosis, treatment plan and provider fee schedules to use.	As discussed during the 2017 Issuer Letter process, MHBE will provide a template for carrier to provide this information. This template will mirror the approach used by HHS for the cost treatment examples required within the SBC already. This information is only meant for consumer transparency purposes. MHBE staff will ask the Board whether it wishes to include these cost-sharing coverage examples within the regulations at this time.
MIA	**14.35.16.07(A)(3):** Many of the network metrics referenced in subsection (3) are unclear and should be defined, such as "average wait time," "average drive time," "average drive distance." These are not standardized metrics, and without specific definitions, each carrier may measure the metrics in a different manner.	MHBE provided this template that mirrors the FFM's proposed definitions of these terms. The proposed provisions have been updated to allow for further specification through Exchange guidance. MHBE staff will ask the Board whether it wishes to include the network metrics within the regulations at this time. Please find the guidance here: http://www.marylandhbe.com/wp-content/uploads/2016/03/FINAL-Operational-Guidance-----Network-Adequacy-Metrics-Template.pdf.

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MIA	**14.35.16.07(C):** It appears that §§(2)(b)-(d), (3), and (4) should be deleted in their entirety. The requirements in these sections would appear to conflict with the provisions of House Bill 1318, Acts of 2016, which have already been agreed to by the Exchange, the Administration, and numerous other interested parties.	As discussed and agreed to with MIA: Provider directory requirements do not contradict or supersede HB1318 requirements. Requirements only incorporate pre-existing federal requirements and minimal processes necessary to maintain CRISP. Network requirements are not quantitative or qualitative standards. Information is intended for consumer transparency only and does not contradict or supersede HB1318 requirements. MHBE staff will ask the Board whether it wishes to include the network metrics within the regulations at this time.
HEAU	**14.35.16.07(C)(2)(d) -** must also meet any statutory standards.	This provision does not exist
MIA	**14.35.16.07(D):** It appears that this regulation should be deleted in its entirety. The requirements in this regulation would appear to conflict with the provisions of House Bill 1318, Acts of 2016, which have already been agreed to by the Exchange, the Administration, and numerous other interested parties.	As discussed and agreed to with MIA: Provider directory requirements do not contradict or supersede HB1318 requirements. Requirements only incorporate pre-existing federal requirements and minimal processes necessary to maintain CRISP. Network requirements are not quantitative or qualitative standards. Information is intended for consumer transparency only and does not contradict or supersede HB1318 requirements. MHBE staff will ask the Board whether it wishes to include the network metrics within the regulations at this time.
MIA	**14.35.16.08:** §§A-C of this regulation (and, to a lesser extent, §D) establish requirements at the "carrier" level. However, the rest of Chapter 16 establishes requirements relating to the certification of an individual "plan." It seems that it may be more appropriate to include Regulation .08 in COMAR 14.35.15, which relates to "carrier certification standards."	Edit incorporated - .08 moved to Chapter 15.

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Carefirst	**14.35.16.08(D)** requires carriers to provide "critical information" to designated individuals. This requirement is vague. Leaving this definition to future interpretation will likely only be duplicative and could create significant problems for stakeholders if it conflicts with their other applicable regulations or accrediting standards. To the extent the Exchange is seeking to identify the provider directory requirements in the 2017 NBPP, it should just cite to those requirements.	.08 moved to Chapter 15. Text updated to mirror federal language.
MIA	**14.35.16.08(D):** §D establishes requirements related to the provision of "critical information" by the carrier to individuals who are or who may become covered under the carrier's plans. It is unclear to us what specific information is considered "critical," and why the information provided in the Summary of Benefits and Coverage is not already sufficient to satisfy the Exchange's requirements.	.08 moved to Chapter 15. Text updated to mirror federal language.
Carefirst	**14.35.16.09(A)** requires carriers to contract with at least 30% of available essential community providers in the plan's service area. No carrier can compel independent third party providers to contract to become a part of their network. Accordingly, CareFirst takes exception to the Exchange's use of "shall" because it simply may not be possible, despite best efforts, to increase the number of essential community providers or require them to contract with CareFirst. In previous correspondence on multiple occasions as recently as January 2016, CareFirst already commented about our concerns on broadening the ECP definition to encompass certain behavioral health providers. We reiterate our concerns here. CareFirst also repeatedly asked for a list of the providers that would be included in this definition. The Exchange indicated that they will work with DHMH to provide a list of the Exchange ECPs at least three to four months prior to June 1. This is unacceptably late to meet a June 1st deadline for submission, as issuers will have insufficient time to negotiate contracts with providers by June 1.	Reference to A(2) incorporated - which is the alternative standard - to clarify that carriers shall meet the 30% threshold as specified or through the alternative standard. MHBE provided the list of state-added ECPs in February and it may be found online here: http://www.marylandhbe.com/news-and-resources/toolbox/carriers-shop-administration/.
MIA	**14.35.16.09(A)(1):** Sub- section (1) indicates that the carrier may list additional essential community providers, but it does not explain where these providers should be listed. Additionally, the cross - references to "45 CFR §156.270" and "Regulation .02(1)(b) through (d)" do not appear to be appropriate.	Amended references to 45 CFR 156.235 and text added to reflect that information should be provided with the carrier's application and in the form provided by the Exchange. Last phrase references the state-added ECPs.

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MIA	**14.35.16.09(A)(1)(b):** The cross- reference to "regulation .05" in paragraph (b) appears incorrect, as that regulation does not mention a "certification application."	Amended reference to "Regulation .04" Plan Certification - Application
MIA	**14.35.16.09(B):** The language of §B appears problematic, as does the definition of "good faith" from Regulation .02B(3). §B requires carriers to offer contracts in good faith to specific types of providers. However, provider contracts are not offered until the provider credentialing process has been completed, and it is the provider, rather than the carrier, that initiates the credentialing process.	Amended B to state "Carriers shall offer the same contract terms to the following essential community providers that a willing, similarly-situated, non-essential community provider would accept or has accepted from the carrier:" This language mirrors the FFM's requirement for contracts offered in good faith. Further, the timing of the contract offer and the initiating party do not interfere with the carrier's ability to offer the contract in good faith. If the comment is intended to express concern about the ability to contract with 30% of ECPs, the carrier may instead meet the ECP requirement through the alternative standard.
Carefirst	**14.35.16.10** appears to repeat governing Maryland Insurance law. However, the draft regulations only summarize or paraphrase portions of the highly complex law governing network adequacy law. This is likely to cause unnecessary conflicting application of the Maryland law and significant confusion for all stakeholders.	Cross reference to Ins. Art. 15-112 incorporated. As network adequacy is a requirement for QHP certification and Chapter 16 is intended to include all Exchange certification requirements, MHBE believes it is important to alert new or continuing entrants to the Exchange of each certification standard.
HEAU	**14.35.16.10 -** HB 1318 has new requirements that must be met. That statutory provision should be cross-referenced.	
MIA	**14.35.16.10:** It appears that this regulation should be deleted in its entirety. The requirements in this regulation would appear to conflict with the provisions of House Bill 1318, Acts of 2016, which have already been agreed to by the Exchange, the Administration, and numerous other interested parties.	Cross reference to Ins. Art. 15-112 incorporated. Network adequacy is a requirement for QHP certification under 45 CFR 155.1050.
HEAU	**14.35.16.11 -** there are statutory standards as well, Insurance 15-831.	Edit incorporated.
MIA	**14.35.16.11(A)(2)(ii):** The reference to "cost-sharing information" should be deleted. To our knowledge, no prescription drug formularies ever include specific cost-sharing information. Also note that the same formulary is typically used by a carrier for many different plans, which each include distinct cost-sharing. Moreover, the federal	Edit incorporated.

Source	Comment	MHBE Response
	requirements under 45 CFR §156.122(d)(i) only require the formulary to include the "tiering structure," not cost sharing information. Finally, note that the "FINAL 2017 Letter to Issuers Seeking to Participate in Maryland Health Connection" issued by the Exchange on January 25, 2016 omitted the requirement for the formulary to include cost sharing information, based on comments previously provided by the Maryland Insurance Administration.	
MIA	**14.35.16.11(A)(4):** It appears that all text in subsection (4) following "A carrier shall comply with 45 CFR §156.122" should be deleted. The current description does not fully comply with the process described in 45 CFR §156.122, and there is really no need to restate requirements that are set forth in detail in the federal regulation.	Amended as proposed
MIA	**14.35.16.12:** The cross-reference to "COMAR 14.35.15.12" appears incorrect, as no such waiver procedure is described in the draft version of that regulation that was submitted to the Administration for comments.	Amended to reference waiver process at COMAR 14.35.15.10
Carefirst	**14.35.16.13** MD. CODE, INS. § 31-115(k)(1)(ii) provides that the Exchange can only take enforcement action against a plan that does not satisfy requirements or has otherwise violated standards for certification that are "not otherwise under the regulatory and enforcement authority of the Commissioner." .13, however, does not clarify that Exchange cannot take enforcement action against a carrier if the MIA has regulatory and enforcement authority in that area. The section should clearly indicate that the Exchange has limited enforcement authority only to the extent the MIA does not regulate the field.	MHBE has updated B and mirrored the statutory text. The Exchange may take action under Ins. Art. 31-115(k) as it pertains to the Exchange's certification of a plan.
Carefirst	**14.35.16.13** It is unclear why .13 is included in the Plan Certification Requirements chapter of Exchange Regulations. Draft 14.35.15.13 already governs the actions the Exchange can pursue against a carrier for failing to comply with applicable requirements. It is not clear the additional regulation is needed here, how it coincides with 14.35.15.13 or why it pertains to plan certification requirements.	Moved from 15 to 16. The regulation provides additional information about the review of a potential violation under Ins. Art. 31-115(k).
David Cooney (MIA)	**14.35.16.13:** This regulation appears unnecessary, as the Exchange already has specific authority under §31-115(k) of the Insurance Article to deny, suspend, or revoke a certification, or impose other penalties.	The regulation provides additional information about the review of a potential violation under Ins. Art. 31-115(k).

Source	Comment	MHBE Response
Carefirst	**14.35.16.13(A)** provides that the Exchange can take action for a carrier's failure to comply with "any other federal or state laws". This provision is overly broad and violates MD. CODE, INS. § 31-115(k)(l)(ii).	MHBE has updated B and mirrored the statutory text. The Exchange may take action under Ins. Art. 31-115(k) as it pertains to the Exchange's certification of a plan.
Carefirst	**14.35.16.13(B)** allows the Exchange to impose sanctions against a carrier if the MIA takes action against a carrier. This provision is overly broad and violates MD. CODE, INS. § 31-ll 5(k)(l)(ii).	MHBE has updated B and mirrored the statutory text. The Exchange may take action under Ins. Art. 31-115(k) as it pertains to the Exchange's certification of a plan.
MIA	**14.35.16.14(B):** We suggest clarifying the text of §B by adding "issues noted by the Exchange during its compliance review" after "…to correct noncompliance."	Amended as proposed