Proposed Action on Regulations

Comparison to Federal Standards Submission and Response

Name:	Maansi Raswant
Agency:	Maryland Health Benefit Exchange
Address:	1000 Hilltop Circle
State:	MD
Zip:	21250
Phone:	410-455-6859
Email:	mraswant@hilltop.umbc.edu

In accordance with Executive Order 01.01.1996.03 and memo dated July 26, 1996, the attached document is submitted to the Department of Business and Economic Development for review.

The Proposed Action is not more restrictive or stringent than corresponding federal standards.

COMAR Codification: 14.35.01.01-.02

COMAR Codification: 14.35.07.01-.21

Corresponding Federal Standard:

45 CFR Part 155, including 45 CFR 155.20, 155.227, 155.230, 155.240, 155.300, 155.305, 155.310, 155.340, 155.345, 155.350, 155.355, 155.400, 155.405, 155.410 and 155.420

Discussion/Justification:

The proposed regulations largely include provisions that an entity doing business with the Maryland Health Benefit Exchange must already adhere to under federal law. Any Maryland-specific provisions are offered as options under federal law or regulation and compliance is not more restrictive or stringent than implementing alternative options.

TO BE COMPLETED BY DBED

X- Agree

_-Disagree

Comments:

The Department of Commerce does not have necessary subject matter expertise in this area. However, Commerce feels that the Maryland Health Benefit Exchange does have the necessary expertise and therefore trusts their assertion that the proposal is not more restrictive/stringent than corresponding federal standards.

Name: Jennifer Cox

Date: 7/20/2016

_-Submit to Governor's Office

Governor's Office Response

Comments:

Transmittal Sheet **PROPOSED OR REPROPOSED** **Actions on Regulations**	**Date Filed with AELR Committee** 07/20/2016	**TO BE COMPLETED BY DSD** Date Filed with Division of State Documents Document Number Date of Publication in MD Register

1. Desired date of publication in Maryland Register: 8/19/2016

2. COMAR Codification

Title	Subtitle	Chapter	Regulation
14	35	01	01-.02
14	35	07	01-.21

3. Name of Promulgating Authority

Maryland Health Benefit Exchange

4. Name of Regulations Coordinator **Telephone Number**
Maansi Raswant 410-455-6859

Mailing Address

1000 Hilltop Circle

City	State	Zip Code
Baltimore	MD	21250

Email
mraswant@hilltop.umbc.edu

5. Name of Person to Call About this Document **Telephone No.**
Vanessa Khoo 410-547-7376

Email Address
vanessa.khoo1@maryland.gov

6. Check applicable items:

_ New Regulations

X- Amendments to Existing Regulations

Date when existing text was downloaded from COMAR online: 6/20/2016.

_ Repeal of Existing Regulations

_ Recodification

_ Incorporation by Reference of Documents Requiring DSD Approval

_ Reproposal of Substantively Different Text:

: Md. R

(vol.) (issue) (page nos) (date)

Under Maryland Register docket no.: --P.

7. Is there emergency text which is identical to this proposal:

_ Yes **X-** No

8. Incorporation by Reference

_ Check if applicable: Incorporation by Reference (IBR) approval form(s) attached and 18 copies of documents proposed for incorporation submitted to DSD. (Submit 18 paper copies of IBR document to DSD and one copy to AELR.)

9. Public Body - Open Meeting

_ OPTIONAL - If promulgating authority is a public body, check to include a sentence in the Notice of Proposed Action that proposed action was considered at an open meeting held pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland.

_ OPTIONAL - If promulgating authority is a public body, check to include a paragraph that final action will be considered at an open meeting.

10. Children's Environmental Health and Protection

_ Check if the system should send a copy of the proposal to the Children's Environmental Health and Protection Advisory Council.

11. Certificate of Authorized Officer

I certify that the attached document is in compliance with the Administrative Procedure Act. I also certify that the attached text has been approved for legality by Sarah Rice, General Counsel, (telephone #410-547-1279) on 6/20/2016. A written copy of the approval is on file at this agency.

Name of Authorized Officer

Carolyn Quattrocki

Title **Telephone No.**

Executive Director 410-547-1270

Date

6/20/2016

Title 14
INDEPENDENT AGENCIES

Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE

14.35.01 General Provisions

Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE

14.35.07 Eligibility Standards for Enrollment in a Qualified Health Plan and a Qualified Health Plan with APTC and CSR in the Individual Exchange

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

Notice of Proposed Action

[]

The Board of Trustees of the Maryland Health Benefit Exchange proposes to amend the title of COMAR 14.35.07 Eligibility and Enrollment to Eligibility Standards for Enrollment in a Qualified Health Plan and a Qualified Health Plan with APTC and CSR in the Individual Exchange. The Board of Trustees of the Maryland Health Benefit Exchange proposes to amend Regulations .01 and .02 under COMAR 14.35.01; amend Regulation .01 under COMAR 14.35.07; and adopt new Regulations .02—.20 under COMAR 14.35.07.

Statement of Purpose

The purpose of this action is to amend the eligibility and enrollment standards for the Individual Exchange to set forth additional detail and conform state regulations to changes in federal regulation. Further, this action provides detail about enrollment effective dates, standards for special enrollment periods, and the due date for the first month's premium payment. The regulations under Subtitle 35 should be read in pari materia with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and associated federal regulations issued before and after their promulgation.

The Maryland Health Benefit Exchange sought feedback on drafts of these regulations from the Maryland Health Benefit Exchange Standing Advisory Committee, the Maryland Insurance Administration, the Department of Health and Mental Hygiene, the Health Education and Advocacy Unit of the Office of the Attorney General and the public. The Maryland Health Benefit Exchange undertook a multi-step process to solicit feedback on multiple drafts of these proposed regulations. Specifically, the Maryland Health Benefit Exchange solicited public written feedback on three occasions and hosted two public meetings to discuss these proposed regulations. Written and

verbal comments received from each of these entities and the public informed these proposed regulations.

Comparison to Federal Standards

There is a corresponding federal standard to this proposed action, but the proposed action is not more restrictive or stringent.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Carolyn Quattrocki, Executive Director, Maryland Health Benefit Exchange, 750 E. Pratt Street, 16th Floor, or call 410-547-1270, or email to mhbe.policy@maryland.gov, or fax to 410-547-7373. Comments will be accepted through September 19, 2016. A public hearing has not been scheduled.

Economic Impact Statement Part C

A. Fiscal Year in which regulations will become effective: FY 2017

B. Does the budget for the fiscal year in which regulations become effective contain funds to implement the regulations?

Yes

C. If 'yes', state whether general, special (exact name), or federal funds will be used:

General, special and federal funds.

D. If 'no', identify the source(s) of funds necessary for implementation of these regulations:

E. If these regulations have no economic impact under Part A, indicate reason briefly:

The proposed regulations largely include provisions that an entity doing business with the Maryland Health Benefit Exchange must already adhere to under federal law. The Maryland Health Benefit Exchange believes that any resources required for an entity to comply with or operate under these proposed regulations can be absorbed with existing resources needed to comply with the obligations generally, which are imposed by federal law and regulation. Any Maryland-specific provisions are offered as options

under federal law or regulation and compliance is not more costly than implementing alternative options. Further, the Maryland Health Benefit Exchange is not seeking to impose fees for participation or impose any other fee at this time.

F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.

Only licensed health insurance carriers offering plans on the Exchange, none of whom are small businesses, and individuals are impacted by these regulations.

G. Small Business Worksheet:

1a. Intended Beneficiaries. Who are the intended beneficiaries of the proposed regulation? Are these intended beneficiaries primarily households or businesses?

Households and licensed health insurance carriers offering plans on the Exchange are the intended beneficiaries.

1b. Intended Beneficiaries: Households. If households are the primary intended beneficiaries, will the proposal affect their income or purchasing power such that the volume or patterns of their consumer spending will change? If so, what directions of change would you anticipate? Will these expected spending changes have a disproportionate impact on small businesses? Can you descriptively identify the industries or types of business activities that are impacted?

The proposal addresses qualifications for enrollment in a qualified health plan. Depending on the household's income and size, among other factors, the household's cost for purchasing a qualified health plan will vary; however, these requirements to do not differ from corresponding federal standards under 45 CFR Part 155. The proposed regulations provide for subsidized health insurance premiums and cost sharing reductions. Households at low and middle income levels tend to spend most or all of increases in available income. It is unknown if increased spending will have a disproportionate impact on small businesses, but it seems unlikely that they would.

1c. Intended Beneficiaries: Businesses. If businesses are the intended beneficiaries, identify the businesses by industry or by types of business activities. How will businesses be impacted? Are these Maryland establishments disproportionately small businesses? If so, how will these Maryland small businesses be affected? Can you identify or estimate the present number of small businesses affected? Can you estimate the present total payroll or total employment of small businesses affected?

Only licensed health insurance carriers offering plans on the Exchange, none of whom are small businesses, are impacted by these regulations. The proposed regulations largely include provisions that an entity doing business with the Maryland Health Benefit Exchange must already adhere to under federal law. The Maryland Health Benefit Exchange believes that any resources required for an entity to comply with or operate under these proposed regulations can be absorbed with existing resources needed to comply with the obligations generally, which are imposed by federal law and

regulation. Any Maryland-specific provisions are offered as options under federal law or regulation and compliance is not more costly than implementing alternative options. Further, the Maryland Health Benefit Exchange is not seeking to impose fees for participation or impose any other fee at this time.

2a. Other Direct or Indirect Impacts: Adverse. Businesses may not be the intended beneficiaries of the proposal. Instead, the proposal may direct or otherwise cause businesses to incur additional expenses of doing business in Maryland. Does this proposal require Maryland businesses to respond in such a fashion that they will incur additional work-time costs or monetary costs in order to comply? Describe how Maryland establishments may be adversely affected. Will Maryland small businesses bear a disproportionate financial burden or suffer consequences that affect their ability to compete? Can you estimate the possible number of Maryland small businesses adversely affected? (Note that small business compliance costs in the area of regulation are the sum of out-of-pocket (cash) costs plus time costs — usually expressed as payroll, akin to calculations for legislative fiscal notes. Precise compliance costs may be difficult to estimate, but the general nature of procedures that businesses must accomplish to comply can be described.)

Only licensed health insurance carriers offering plans on the Exchange, none of whom are small businesses, are impacted by these regulations. The proposed regulations largely include provisions that an entity doing business with the Maryland Health Benefit Exchange must already adhere to under federal law. The Maryland Health Benefit Exchange believes that any resources required for an entity to comply with or operate under these proposed regulations can be absorbed with existing resources needed to comply with the obligations generally, which are imposed by federal law and regulation. Any Maryland-specific provisions are offered as options under federal law or regulation and compliance is not more costly than implementing alternative options. Further, the Maryland Health Benefit Exchange is not seeking to impose fees for participation or impose any other fee at this time.

2b. Other Direct or Indirect Impacts: Positive. Maryland businesses may positively benefit by means other than or in addition to changed consumer spending patterns. How may Maryland businesses be positively impacted by this initiative? Will Maryland small businesses share proportionately or disproportionately in these gains? Can you estimate the possible number of Maryland small businesses positively affected?

These proposed regulations address the requirements for enrollment in a qualified health plan through the Maryland Individual Exchange. Such qualified health plans are offered by licensed health insurance carriers doing business in the Maryland Individual Exchange; however none of these carriers include small businesses. The regulations will have a positive impact on the carriers by reducing business uncertainty while allowing sufficient time to implement any needed operational changes.

3. Long-Term Impacts. There are instances where the longer run economic impact effect from regulations differ significantly from immediate impact. For example,

regulations may impose immediate burdens on Maryland small businesses to comply, but the overall restructuring of the industry as a consequence of monitoring and compliance may provide offsetting benefits to the affected small businesses in subsequent years. Can you identify any long run economic impact effects on Maryland small businesses that over time (a) may compound or further aggravate the initial economic impact described above, or (b) may mitigate or offset the initial economic impact described above?

No small businesses are impacted; however, the Maryland Health Benefit Exchange believes that any resources required for an entity to comply with or operate under these proposed regulations can be absorbed with existing resources needed to comply with the obligations generally, which are imposed by federal law and regulation. Any Maryland-specific provisions are offered as options under federal law or regulation and compliance is not more costly than implementing alternative options. Further, the Maryland Health Benefit Exchange is not seeking to impose fees for participation or impose any other fee at this time. If corresponding federal regulations are amended, the Exchange would review and amend these regulations accordingly, which may affect businesses in the future.

4. Estimates of Economic Impact. State Government Article, §2-1505.2 requires that an agency include estimates, as appropriate, directly relating to: (1) cost of providing goods and services; (2) effect on the work force; (3) effect on the cost of housing; (4) efficiency in production and marketing; (5) capital investment, taxation, competition, and economic development; and (6) consumer choice.

(1) There is no anticipated effect on the cost of providing goods and services; (2) There is no anticipated effect on the work force; (3) There is no effect on the cost of housing; (4) There may be a positive effect on efficiency in production and marketing by the use of specified processes because uncertainty is reduced; (5) There is no anticipated capital investment, taxation, competition, and economic development; and (6) There is a positive effect on consumer choice as this information will assist a consumer in applying for and enrolling in coverage through the Maryland Individual Exchange.

Attached Document:

Title 14 INDEPENDENT AGENCIES

Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE

14.35.01 General Provisions

Authority: Insurance Article, §31-106(c)(1)(iv), Annotated Code of Maryland

14.35.01.01 (6/20/16)

.01 Compliance with Federal Law.

[The Maryland Health Benefit Exchange shall comply with all provisions of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and all associated guidance and regulations hereto and hereafter issued.] *The regulations under Subtitle 35 should be read in pari materia with the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and associated federal regulations issued before and after their promulgation.*

14.35.01.02 (6/20/16)

.02 Definitions.

In this subtitle, the following terms have the meanings indicated.

(1) (text unchanged)

(2) ["Advanced Premium Tax Credit" has the meaning stated in 45 CFR §155.20.] *"Actuarial value" means the percentage paid by a health benefit plan of the percentage of the total allowed costs of benefits as set forth in 45 CFR §156.140.*

(3) ["MCHP" means the Maryland Children's Health Program.] *"Advance payments of the premium tax credit (APTC)" means payment of the federal tax credits authorized by 26 U.S.C. §36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a qualified health plan through the Exchange under §1412 of the Affordable Care Act.*

(4) "Affordable Care Act (ACA)" means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111-148), as amended, including by the Health Care and Education Reconciliation Act of 2010 (Pub. L. No. 111-152), and the regulations issued under it.

(5) "Board" has the meaning stated in Insurance Article, §31-101, Annotated Code of Maryland.

[(4) "CARES" means the case management data system that tracks eligibility for Medicaid and other social services.]

[(5)] *(6)* (text unchanged)

(7) "Catastrophic plan" means a QHP described in §1302(e) of the Affordable Care Act.

[(6)] (*8*) "Commissioner" means the [Maryland Insurance] Commissioner *of the Maryland Insurance Administration*.

(9) "Cost sharing" means any expenditure required by or on behalf of an enrollee with respect to covered benefits.

(a) Cost sharing includes deductibles, coinsurance, copayments, or similar charges.

(b) Cost sharing does not include premiums, balance billing amounts for non-network providers, and spending for non-covered services.

[(7)] (*10*) "Cost Sharing Reductions" has the meaning stated in 45 CFR §155.20.

(11) "Coverage" means a qualified individual's enrollment in a qualified plan.

(12) "Coverage level" has the meaning stated in Insurance Article, §31-101, Annotated Code of Maryland.

[(8)] *(13)* ["Department" means the Department of Health and Mental Hygiene.] *"Dental plan" means a plan that provides limited scope dental benefits as described in Insurance Article, §31-108(b)(2), Annotated Code of Maryland.*

(14) "Eligibility determination" means a decision by the Individual Exchange about an applicant's eligibility to enroll in a QHP, catastrophic plan or insurance affordability program or terminate a qualified individual's enrollment in a QHP or insurance affordability program during an open enrollment period or special enrollment period.

(15) "Enrollee" means a qualified individual who is enrolled in a qualified plan through the Individual Exchange.

(16) "Enrollment" means the enrollee's QHP purchased through the Individual Exchange.

[(9)] (*17*) "Exchange" [has the meaning stated in Insurance Article §31-101(e), Annotated Code of Maryland] *means the Maryland Health Benefit Exchange established as a public corporation under Insurance Article, §31-102, Annotated Code of Maryland, and includes the Individual Exchange and the Small Business Health Options Program*.

[(10)] (*18*) (text unchanged)

(19) "Grace period" means the period of time during which an authorized carrier is prohibited from terminating an enrollee's enrollment in a qualified health plan obtained through the Individual Exchange due to nonpayment of premiums, as specified in:

(a) Insurance Article, §15-1315(c)—(e), Annotated Code of Maryland, if the enrollee is receiving APTC; or

(b) Insurance Article, §15-209, Annotated Code of Maryland, for insurers; COMAR 31.10.25.04C, for non-profit health service plans; COMAR 31.12.07.05D, for HMOs; or COMAR 31.12.04.05A, for dental plan organizations, if the enrollee is not receiving APTC.

(20) "Health benefit plan" has the meaning stated in Insurance Article, §31-101, Annotated Code of Maryland.

(21) "Health Maintenance Organization" (HMO) has the meaning stated in Health-General Article, §19-701(g), Annotated Code of Maryland.

(22) "HHS" means the federal Department of Health and Human Services.

[(11)] (*23*) "Individual Exchange" has the meaning stated in Insurance Article §31-101[(h)], Annotated Code of Maryland.

[(12)] (*24*) "Individual Exchange Navigator" has the meaning stated in Insurance Article §31-101[(i)], Annotated Code of Maryland.

[(13)] (*25*) "Individual Exchange Navigator Certification" has the meaning stated in Insurance Article §31-101[(j)], Annotated Code of Maryland.

[(14)] (*26*) "Individual Exchange Navigator Entity" has the meaning stated in Insurance Article §31-101[(k)], Annotated Code of Maryland.

[(15)] (*27*) "Insurance Producer" has the meaning stated in Insurance Article §1-101[(u)], Annotated Code of Maryland.

[(16)] (*28*) "Insurance Producer Authorization" has the meaning stated in Insurance Article §31-101[(m)], Annotated Code of Maryland.

[(17)] (*29*) (text unchanged)

[(19)] (*30*) (text unchanged)

(31) "Maryland Health Benefit Exchange" has the meaning stated in Insurance Article, §31-101, Annotated Code of Maryland.

[(18-19)] (*32-33*) (text unchanged)

(34) "Maryland Insurance Administration (MIA)" means the insurance administration for the State established under Insurance Article, §2-101, Annotated Code of Maryland.

[(20)] (*35*) (text unchanged)

(36) "Minimum Essential Coverage (MEC)" has the meaning stated in 26 USC §5000A(f) and the corresponding regulation under 26 CFR §1.5000A-2(c).

[(21)] (*37*) (text unchanged)

(38) "Non-Exchange entity" means any individual or entity in a contractual or agent relationship with the Exchange that because of the contractual or agent relationship:

(a) Gains access to personally identifiable information submitted to an Exchange; or

(b) Collects, uses, or discloses personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing functions agreed to with the Exchange.

[(22)] (*39*) (text unchanged)

(40) "Plan variation" means a zero cost sharing plan variation or a silver plan variation.

(41) "Product" has the meaning stated in Insurance Article, §15-1309, Annotated Code of Maryland.

(42) "Qualified dental plan (QDP)" has the meaning stated in Insurance Article, §31-101, Annotated Code of Maryland.

(43) "Qualified health plan (QHP)" has the meaning stated in Insurance Article, §31-101, Annotated Code of Maryland.

[(23)] (*44*) "Qualified Individual" has the meaning stated in Insurance Article, §31-101[(s)], Annotated Code of Maryland.

(45) "Qualified plan" has the meaning stated in Insurance Article, §31-101, Annotated Code of Maryland.

(46) "Silver plan variation" means any of the cost-sharing reduction plan variations of a silver QHP set forth at 45 CFR §156.420(a).

(47) "Single, streamlined application form" means the one eligibility application form that an applicant may use to apply for enrollment in a QHP or insurance affordability program through the Individual Exchange.

(48) "Small Business Health Options Program (SHOP) Exchange" has the meaning stated in Insurance Article, 31-101, Annotated Code of Maryland.

(49) "Special enrollment period" means the only periods outside of the annual open enrollment period during which a qualified individual or enrollee, or, where applicable, the qualified individual or enrollee's dependent, who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Individual Exchange outside of the open enrollment period.

(50) "Stand-alone dental plan (SADP)" means a qualified dental plan that meets the requirements set forth at 45 CFR 155.1065(a).

(51) "Zero cost sharing plan variation" means the cost-sharing reduction plan variation of a QHP set forth at 45 CFR §156.420(b)(1).

Title 14 INDEPENDENT AGENCIES

Subtitle 35 MARYLAND HEALTH BENEFIT EXCHANGE

14.35.07 Eligibility *Standards for* [and] Enrollment *in a Qualified Health Plan and a Qualified Health Plan with APTC and CSR in the Individual Exchange*

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

14.35.07.01 (6/20/16)

.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 a qualified health plan and a qualified health plan with advance payments of the premium tax credit and cost-sharing reductions in the Individual Exchange. This chapter does not address verification of eligibility or redeterminations of eligibility for enrollment in the Individual Exchange or eligibility for enrollment in the SHOP Exchange. This chapter does not address eligibility and enrollment in qualified dental plans or qualified vision plans.

.02 Definitions.

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

B. Terms Defined.

(1) "Applicant" means an individual who submits an application through the Individual Exchange for the individual and the individual's tax household and is seeking eligibility for:

(a) Enrollment in a QHP through the Individual Exchange; or

(b) Enrollment in an insurance affordability program through the Individual Exchange.

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

(3) "CSR plan for up to 150 percent FPL" means a QHP available through the Individual Exchange with an actuarial value of 94 percent plus or minus the de minimis variation for a silver plan variation.

(4) "CSR plan for 151-200 percent FPL" means a QHP available through the Individual Exchange with an actuarial value of 87 percent plus or minus the de minimis variation for a silver plan variation.

(5) "CSR plan for 201-250 percent FPL" means a QHP available through the Individual Exchange with an actuarial value of 73 percent plus or minus the de minimis variation for a silver plan variation.

(6) "Dependent", under Regulations .12—.19 of this chapter, has the meaning stated in 26 CFR §54.9801-2.

(7) "Employer–sponsored coverage" means health coverage offered by an employer to an employee and the employee's dependents, if eligible, under:

(a) Government health coverage, such as the Federal Employees Health Benefit program;

(b) Health coverage offered in the small or large group market by an employer within a state; or

(c) Grandfathered health coverage offered by an employer in a group market.

(8) "Federal Poverty Level (FPL)" means the most recently published federal poverty level guidelines, updated periodically in the Federal Register by the Secretary of HHS as set forth in 42 U.S.C. §9902(2), as of the first day of the open enrollment period for QHPs offered through the Individual Exchange for a calendar year.

(9) "Household income" has the meaning stated in §36B(d)(2) of the Internal Revenue Code.

(10) "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 under 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.

(11) "Institution" means:

(a) A medical institution set forth in COMAR 10.09.24.02.37; or

(b) A public institution set forth in COMAR 10.09.24.02.46.

(12) "Insurance affordability programs" means a program that is one of the following:

(a) The Maryland State Medicaid program;

(b) The Maryland Children's Health Insurance Program (CHIP), including the program known as Maryland Children's Health Program (MCHP) Premium;

(c) A program that makes available to qualified individuals coverage in a QHP through the Individual Exchange with APTC as set forth in §36B of the Internal Revenue Code; or

(d) A program that makes available to qualified individuals coverage in a QHP through the Individual Exchange with CSR as set forth in §1402 of the ACA.

(13) "Non-applicant" means an individual who is not seeking eligibility for enrollment in a QHP or an insurance affordability program through the Individual Exchange.

(14) "Rescission" means a cancellation or discontinuance of coverage that:

(a) Has retroactive effect; and

(b) Meets a permissible circumstance set forth in 45 CFR §147.128.

(15) "Tax filer" means an individual, or a married couple, who indicates that the tax filer expects:

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

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

(c) To not be claimed as a tax dependent by any other taxpayer for the benefit year; and

(d) To claim a personal exemption deduction set forth in §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.

(16) "Qualifying eligible employer-sponsored plan" means a health benefit plan that meets the requirements set forth in 26 CFR §1.36B-2(c)(2)(i).

.03 Applying for Coverage through the Individual Exchange.

A. An individual may apply to enroll in a QHP or an insurance affordability program through the Individual Exchange using the single, streamlined application form approved by the Individual Exchange.

B. An individual may submit the application:

(1) By telephone;

(2) On the Individual Exchange's internet website;

(3) Using in-person assistance available through the Individual Exchange, including with provision of reasonable accommodations; or

(4) By mail.

C. An applicant shall provide the following information on the application:

(1) The applicant's and applicable dependents' social security number, if the individual has a social security number;

(2) An authorization for the Individual Exchange to verify attested information through electronic means;

(3) An election indicating whether the applicant is seeking an eligibility determination for enrollment in a QHP or insurance affordability programs;

(4) If the applicant is applying for enrollment in a QHP, sufficient information to determine eligibility for enrollment in a QHP;

(5) If the applicant is applying for enrollment in insurance affordability programs, sufficient information to determine eligibility for enrollment in insurance affordability programs;

(6) If the applicant is applying for enrollment in an insurance affordability program under Regulation .02B(12)(c) or .02B(12)(d) of this chapter and the applicant files an income tax return as a married couple, an attestation that the applicant intends to file a joint 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 attestation may provide that the applicant intends to file a single income tax return for the benefit year in which the individual is seeking coverage; and

(b) If the individual in a married couple qualifies to file as head of household, the attestation may provide that the applicant will file an income tax return as head of household for the benefit year in which the individual is seeking coverage; and

(7) The applicant's signature, including either an electronic or telephonic signature, under penalties of perjury.

D. Non-Applicant.

(1) A non-applicant who applies for insurance affordability programs on behalf of a member in the non-applicant's tax filing household shall provide the following information on the application:

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

(b) The non-applicant's social security number, if the applicant attests that the tax filer:

i. Has a social security number; and

ii. Filed a tax return for the year for which tax data would be used to verify the applicant's household income and family size.

(2) A non-applicant shall provide the following information on the application if the only members of the individual's household who are seeking coverage are younger than 18 years old and are not emancipated minors:

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

(b) The non-applicant's address.

(3) Non-applicants are not required to provide information about the non-applicant's citizenship, status as a national, or immigration status.

E. An individual who applies for an insurance affordability program shall receive an eligibility determination for all of the insurance affordability programs.

F. An individual may submit an application to the Individual Exchange and receive an eligibility determination at any time during the year.

G. Incomplete Applications.

(1) If an individual submits an incomplete application, the Individual Exchange shall send the individual a notice under Regulation .04(D) of this chapter.

(2) The individual shall have 90 days to complete the application and receive an eligibility determination from the date of the notice under Regulation .04(D) is sent to the individual.

.04 Notice Requirements

A. The Individual Exchange shall provide timely written notice to an applicant of any eligibility determination made under this chapter as set forth in 45 CFR §155.310(g) and a notification of the right to request a fair hearing as set forth in COMAR 14.35.11.04.

B. If an employee enrolls in a QHP with APTC or CSR, the Individual Exchange shall notify the employee's employer at the employer's address provided by the employee to the Individual Exchange that the employee has been determined eligible for APTC or CSR.

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

(1) Identify the employee by including:

(a) The employee's name;

(b) The employee's date of birth;

(c) The last four digits of the employee's social security number, if available; and

(d) The employee's Individual Exchange identification number;

(2) Indicate that the employee has been determined eligible for APTC or CSR and has enrolled in a QHP;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the shared responsibility payment assessment set forth in §4980H of the Internal Revenue Code; and

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

D. The Individual Exchange shall send a notice to an applicant who submits an application containing insufficient information for the Individual Exchange to conduct an eligibility determination.

E. The notice under §D of this regulation shall:

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

(2) Specify the missing information;

(3) Provide instructions on how to provide the missing information to the Individual Exchange; and

(4) Specify that the applicant shall have 90 days to provide the missing information to the Individual Exchange beginning on the date of the notice.

F. If an applicant or enrollee has designated an authorized representative under Regulation .21 of this chapter, the Individual Exchange shall provide:

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

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

G. The Individual Exchange shall provide written notices electronically to an individual if:

(1) The individual elects to receive notices electronically;

(2) The individual is mailed confirmation of the individual's election to receive notices electronically;

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

(4) The Individual Exchange posts notices in the individual's online Individual Exchange account within 1 business day of generation of the electronic notice; and

(5) Within 1 business day of generating the electronic notice, the Individual Exchange electronically mails the individual at the individual's verified electronic mail address alerting the individual to the existence of the electronic notice in the individual's online Individual Exchange account.

H. If the electronic communication under §G(5) of this regulation fails to be sent to the individual, the Individual Exchange shall mail a written notice of the failed electronic communication to the individual's mailing address.

I. An individual may request a written copy of any electronic notice the individual receives from the Individual Exchange.

.05 Eligibility Requirements for Enrollment in a Qualified Health Plan through the Individual Exchange.

A. An applicant shall be determined eligible for enrollment in a QHP through the Individual Exchange if the applicant is:

(1) A citizen or national of the United States, or a non-citizen who is lawfully present in the United States, and reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

(2) A resident of the Individual Exchange service area; and

(3) Not incarcerated, other than incarceration pending the disposition of charges.

B. Eligibility under this regulation is contingent upon verification of the applicant's attestation that the applicant meets the criteria stated in §A of this regulation.

.06 General Eligibility Requirements—Citizenship and Immigration Status.

A. For purposes of determining eligibility for enrollment in a QHP under Regulation .05A(1) of this chapter, an individual shall be considered a citizen or national of the United States 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 or adoptive parents or stepparents is a United States citizen by birth or naturalization;

iii. The child is younger than 18 years old;

iv. The child resides 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 determining eligibility for enrollment in a QHP under Regulation .05A(1) of this chapter, an individual shall be considered lawfully present if the individual is:

(1) An alien who has been 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 set forth in §212(d)(5) of the INA;

(3) An alien who has been paroled into the United States set forth in 8 U.S.C. §1182(d)(5) for less than 1 year, except for an alien paroled for prosecution or 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; or

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

(5) A refugee admitted as set forth in §207 of the INA;

(6) An alien granted asylum set forth in §208 of the INA;

(7) An alien whose deportation is being withheld set forth in:

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

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

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

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

(10) A child receiving federal payments for foster care or adoption assistance set forth in 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, as set forth in §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 a nonimmigrant status who has not violated the terms of the status under which the alien was admitted, or to which the alien has changed after admission;

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

(14) An alien currently under Temporary Protected Status (TPS) set forth in §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 set forth in 8 CFR §§274a.12(c)(9), (10), (16), (18), (20), (22), or (24);

(16) A Family Unity beneficiary set forth in §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 of the United States;

(18) An alien currently in deferred action status;

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

(20) A pending applicant for asylum set forth in 8 U.S.C. §1158 who:

(a) Is under the age of 14; and

(b) Has had an application pending for at least 180 days;

(21) A pending applicant for withholding of removal, set forth in 8 U.S.C. §1231 or under the Convention Against Torture who:

(a) Has been granted employment authorization;

(b) Is under the age of 14; and

(c) Has had an application pending for at least 180 days;

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

(23) A child who has a pending application for a Special Immigrant Juvenile status set forth in 8 U.S.C. §1101(a)(27)(J).

.07 General Eligibility Requirements—Residency in Individual Exchange Service Area.

A. For the purpose of determining eligibility for enrollment in a QHP under Regulation .05(A)(2) of this chapter, an individual shall be considered a resident of the Individual Exchange service area if:

(1) An individual is 21 years old or older, is not living in an institution, is capable of indicating intent, and is not receiving an optional State supplementary payment, and the individual:

(a) Lives in the Individual Exchange service area;

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

(c) Has entered into a job commitment or is seeking employment, whether or not currently employed, in the Individual Exchange service area; or

(2) An individual is younger than 21 years old, 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 the individual either:

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

(b) Resides with a parent or caretaker who resides in the service area of the Individual Exchange under §A(1) of this regulation.

B. For an individual not described in §A of this regulation, an individual shall be considered a resident of the Individual Exchange service area if the individual meets the State residency requirements set forth in COMAR 10.09.24.05-3.

C. If members of the tax household are not residents of the same Individual Exchange service area, the tax household may indicate any Individual Exchange for which one of the tax filers meets the residency standard under this regulation as the tax household's residency.

D. If both spouses in a tax household enroll in a QHP through the Individual Exchange, a tax dependent may only enroll in a QHP through the Individual Exchange, or through a different health benefit exchange for which the dependent meets the residency standard.

E. The Individual Exchange may not deny or terminate an individual's eligibility for enrollment in a QHP through the Individual Exchange if the individual meets the residency standard under this regulation but for a temporary absence from the service area of the Individual Exchange and the individual intends to return when the purpose of the absence has been accomplished.

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

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

A. A tax filer shall be determined eligible for APTC 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 the applicant's federal tax return for the benefit year:

(a) Meets the eligibility requirements for enrollment in a QHP through the Individual Exchange, under Regulation .05 of this chapter; and

(b) Is not eligible for minimum essential coverage, with the exception of coverage in the individual market as set forth in 26 CFR §1.36B-2(a)(2) and (c).

B. 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 under §A(2) of this regulation;

(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 the tax filer's return for the benefit year is a non-citizen who is lawfully present and ineligible for Medicaid or MCHP by reason of immigration status.

C. APTC may be received by a tax filer for another qualified individual only if one or more qualified individuals for whom the tax filer attests that the tax filer expects to claim a personal exemption deduction for the benefit year, including the tax filer and the tax filer's spouse, is enrolled in a QHP that is not a catastrophic plan, through the Individual Exchange.

D. If one or more APTC amounts are to be made on behalf of a tax filer, or two tax filers covered by the same plan or plans, and individuals in the tax filers' tax households are enrolled in more than one QHP and stand-alone dental plan, then the APTC amounts shall be allocated as follows:

(1) That portion of the APTC that is less than or equal to the aggregate adjusted monthly premiums, set forth in 26 CFR §1.36B-3(e), and that is properly allocated to essential health benefits shall 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 APTC may be allocated to the essential health benefit portion of any stand-alone dental plans.

E. A tax filer shall not be eligible for APTC if:

(1) HHS notifies the Individual Exchange that APTC 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 set forth in 45 CFR §155.320(c)(1)(i); and

(2) The tax filer or spouse did not file a federal income tax return for that year and did not reconcile the APTC received for that year.

F. APTC shall be calculated as set forth in 26 CFR §1.36B-3.

G. The tax filer shall attest to the following to receive APTC:

(1) No other tax filer will claim the tax filer as a tax dependent for the benefit year; and

(2) 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 Individual Exchange, under Regulation .05 of this chapter; and

(b) Are not eligible for minimum essential coverage.

H. An enrollee may accept less than the full amount of APTC for which the enrollee is determined eligible.

I. Effective dates for changes in eligibility for APTC.

(1) Except as otherwise specified under this regulation, changes in eligibility for APTC are effective:

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

(b) The first day of the second following month, for changes in eligibility determined by the Individual Exchange between the sixteenth and the last day of a month.

(2) When an enrollee is determined newly eligible for Medicaid or MCHP, the enrollee shall not be eligible for APTC beginning the first of the month after the enrollee is determined newly eligible for Medicaid or MCHP.

(3) When an applicant or enrollee is eligible for a special enrollment period under Regulations .12—.19 of this chapter, in accordance with the applicable effective date specified for each special enrollment period under Regulations .12—.19 of this chapter.

(4) When an enrollee's enrollment is terminated as set forth in 45 CFR §155.430, in accordance with the applicable effective date of the termination set forth in 45 CFR §155.430.

J. Eligibility under this regulation is contingent upon verification of the applicant's attestation that the applicant meets the criteria stated in this regulation.

.09 Eligibility Requirements for Cost-Sharing Reductions.

A. An applicant shall be determined eligible for cost-sharing reductions if the applicant:

(1) Meets the requirements for eligibility for enrollment in a QHP through the Individual Exchange under Regulation .05 of this chapter;

(2) Meets the requirements for APTC under Regulation .08 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 percent of the 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 APTC under Regulation .07B 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 percent FPL for an individual who 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 percent 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, any coverage level for an individual who attests to household income greater than 250 percent 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 the individuals were to enroll in separate individual policies, would be eligible for different CSR plan variations, the individuals under the 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;

(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.

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

E. Special Cost-Sharing Rules for Indians.

(1) An applicant who is an Indian is eligible for the zero-cost sharing plan variation of a QHP if the applicant:

(a) Meets the requirements for eligibility for enrollment in a QHP through the Individual Exchange pursuant to Regulation .05 of this chapter;

(b) Meets the requirements for APTC pursuant to Regulation .08 of this chapter; and

(c) Attests to household income set forth 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 QHP 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. Changes in enrollment in a plan with CSR under this regulation is effective based on the effective dates under Regulation .08I of this chapter.

G. Eligibility under this regulation is contingent upon verification of the applicant's attestation that the applicant meets the criteria stated in this regulation.

.10 Eligibility Requirements for Enrollment in a Catastrophic Plan.

A. An applicant shall be determined eligible for enrollment through the Individual Exchange in a catastrophic plan if the applicant has met the requirements for eligibility for enrollment in a QHP through the Individual Exchange under Regulation .05 of this chapter and either:

(1) Is younger than 30 years old before the beginning of the plan year; or

(2) Has a certification in effect for any plan year that the applicant is exempt from the requirement to maintain minimum essential coverage set forth in §5000A of the Internal Revenue Code by reason of:

(a) §5000A(e)(1) of the Internal Revenue Code, regarding individuals without affordable coverage; or

(b) §5000A(e)(5) of the Internal Revenue Code, regarding individuals with hardships.

B. Changes in enrollment in a catastrophic plan under this regulation is effective based on the effective dates under Regulation .08I of this chapter.

C. Eligibility under this regulation is contingent upon verification of the applicant's attestation that the applicant meets the criteria stated in this regulation.

.11 Enrollment in a QHP or Insurance Affordability Program through the Individual Exchange.

A. A qualified individual may enroll in a QHP or an insurance affordability program, except for the programs under Regulations .02B(12)(a) and .02B(12)(c) of this chapter, through the Individual Exchange only during:

(1) The annual open enrollment period of the Individual Exchange, or

(2) A special enrollment period for which the Individual Exchange has determined that the qualified individual is eligible.

B. The annual open enrollment period for the Individual Exchange shall:

(1) Be November 1, 2015 through January 31, 2016 for the benefit year beginning on January 1, 2016;

(2) Be November 1, 2016 through January 31, 2017 for the benefit year beginning on January 1, 2017; and

(3) Follow any amendments to 45 CFR §155.410 and any accompanying HHS guidance.

C. Coverage selected during an open enrollment period shall:

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

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

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

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

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

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

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

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

(3) Follow any amendments to 45 CFR §155.410 and any accompanying HHS guidance.

D. If an individual enrolls in a QHP, the Individual Exchange shall promptly and without undue delay transmit to the carrier of the QHP the information necessary to enable the QHP's carrier to enroll the qualified individual in the QHP selected by the qualified individual, including:

(1) The qualified individual's selected QHP;

(2) The qualified individual's eligibility or change in eligibility for APTC or a CSR plan, if applicable;

(3) Whether the carrier should apply, remove, or change the total amount of the qualified individual's APTC, if applicable; and

(4) The dollar amount of the APTC, if any.

E. Payment of First Month's Premium.

(1) A qualified individual shall pay the first month's premium to the carrier of the QHP to effectuate enrollment in the QHP when the individual has:

(a) Enrolled in a QHP after a break from a previous enrollment in a QHP in the Individual Exchange;

(b) Enrolled for the first time in a QHP in the Individual Exchange; or

(c) Elected a different QHP product from the same carrier in the Individual Exchange.

(2) The first month's premium payment is required if the qualified individual enrolls in a QHP offered by a different carrier of the same holding company in the Individual Exchange.

(3) The first month's premium payment to effectuate prospective coverage for QHP selections made during an annual open enrollment period or during a special enrollment period under Regulations .13E(4), .18F(1), and .19C of this chapter shall be due on a uniformly applied date specified by the authorized carrier of the QHP that is no earlier than the coverage effective date and no later than 30 calendar days from the coverage effective date.

(4) Effective January 1, 2018, the first month's premium payment to effectuate prospective coverage for QHP selections made during an annual open enrollment period or during a special enrollment period described in Regulations .13E(4), .18F(1), and .19C of this chapter shall be due on or before the 7th day from the coverage effective date.

(5) The first month's premium payment to effectuate prospective coverage for QHP selections made during a special enrollment period under Regulations .12E, .13E(1)—(3), .14E, .15D, .16C, .17D and .18F(2) of this chapter shall be due on a uniformly applied date specified by the authorized carrier of the QHP that is no earlier than the coverage effective date and no later than 30 calendar days from the date the carrier receives the enrollment transaction from the Individual Exchange or the coverage effective date, whichever is later.

(6) Effective January 1, 2018, the first month's premium payment to effectuate prospective coverage for QHP selections made during a special enrollment period under Regulations .12E, .13E(1)—(3), .14E, .15D, .16C, .17D and .18F(2) of this chapter shall be due on or before the 7th day from the coverage effective date.

(7) Payment to effectuate retroactive coverage shall include the premium due for all months of retroactive coverage and shall also include the full premium amount of the first prospective month of coverage.

(8) Payment to effectuate retroactive coverage for QHP selections made during a special enrollment period shall be due on a uniformly applied date specified by the authorized carrier that is no earlier than the coverage effective date and no later than 30 calendar days from the date the carrier receives the enrollment transaction from the Individual Exchange or the coverage effective date, whichever is later.

(9) Effective January 1, 2018, payment to effectuate retroactive coverage for QHP selections made during a special enrollment period under Regulations .13E(2) and (3), .14E, .15D, .16C and .17D of this chapter shall be due on or before the 7th day of the first full prospective coverage month.

(10) If the premium amount for only one month of coverage is paid to effectuate retroactive coverage, the carrier shall effectuate prospective coverage only for the qualified individual.

(11) An authorized carrier may choose to extend the premium due date under §E of this regulation if the carrier does so in a uniform and consistent manner for all similarly-situated applicants.

F. An authorized carrier may establish a premium payment threshold policy.

(1) Under a premium payment threshold policy the authorized carrier may consider the qualified individual or enrollee to have paid all amounts due if the enrollee pays an amount sufficient to maintain a percentage of the total premium paid out of the total premium owed equal to or greater than a level determined by the carrier.

(2) If an authorized carrier establishes a premium payment threshold policy, the authorized carrier shall:

(a) Determine a premium payment level that is reasonable; and

(b) Apply the premium payment level and the premium payment threshold policy in a uniform manner to all qualified individuals and enrollees.

(3) If a qualified individual or enrollee satisfies the authorized carrier's premium payment threshold policy, the authorized carrier shall:

(a) Effectuate an enrollment based on payment of the initial premium payment under §E of this regulation;

(b) Avoid triggering a grace period for non-payment of premium set forth in:

i. Insurance Article, §31-1315(c) through (e), if the enrollee is receiving APTC; or

ii. Insurance Article §15-209, Annotated Code of Maryland (for insurers), COMAR 31.10.25.04C (for nonprofit health services plans), or COMAR 31.12.07.05D (for HMOs), if the enrollee is not receiving APTC; and

(c) Avoid terminating the enrollment for non-payment of premium set forth in 45 CFR §155.430(b)(2)(ii).

G. An authorized carrier shall accept and process an enrollment for a qualified individual that does not include a social security number.

H. The Individual Exchange shall maintain records of all enrollments through the Individual Exchange.

.12 Special Enrollment Periods—Loss of Minimum Essential Coverage or Termination of Other Specified Coverage.

A. A qualified individual and, when specified in this regulation, an enrollee, a qualified individual's dependent or an enrollee's dependent, are eligible for a special enrollment period for loss of minimum essential coverage or other specified coverage if:

(1) The qualified individual or the qualified individual's dependent loses eligibility for minimum essential coverage;

(2) The qualified individual or the qualified individual's dependent loses eligibility for qualifying eligible 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) The individual's 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) The 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 the individual's coverage; or

(k) The qualified individual or qualified individual's 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 set forth in 26 CFR §1.36B-2(c)(3), including as a result of the qualified individual's employer discontinuing or changing available coverage within the next 60 days, if the qualified individual or the qualified individual's dependent is permitted by the employer and applicable federal laws to terminate enrollment in the employer-sponsored plan;

(3) A qualified individual or the qualified individual's dependent loses eligibility for employer-sponsored coverage that is COBRA continuation coverage or continuation coverage under State law because the individual exhausted COBRA continuation coverage or continuation coverage under State law;

(4) A qualified individual or a qualified individual's dependent was enrolled in coverage through a non-calendar year group health plan or individual health insurance coverage and the policy or plan year ends in the middle of the calendar year, even if the qualified individual or the qualified individual's dependent has the option to renew the coverage;

(5) A qualified individual or the qualified individual's dependent loses pregnancy-related coverage set forth in COMAR 10.09.24.03A(2);

(6) A qualified individual or the qualified individual's dependent loses medically needy coverage set forth in COMAR 10.09.24.03E; or

(7) An enrollee or an enrollee's dependent loses coverage in a QHP because the QHP 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 failure to pay COBRA premiums prior to expiration of COBRA coverage;

(2) A change in eligibility status set forth in 45 CFR §155.315(f)(5) because the individual does not meet the requirement specified under Regulation .05 of this chapter; or

(3) An authorized carrier's valid rescission of coverage.

C. The date of loss of minimum essential coverage or other coverage is the date the qualified individual, the enrollee, the qualified individual's dependent, or the enrollee's dependent:

(1) Loses eligibility for minimum essential coverage under the previous plan; or

(2) The coverage under §§A(1) and A(3)—(7) of this regulation terminates.

D. To be eligible for a special enrollment period under this regulation, a qualified individual, an enrollee, a qualified individual's dependent or an enrollee's dependent shall:

(1) Report the loss of minimum essential coverage or the termination of coverage under §§A(1) and A(3)—(7) of this regulation; and

(2) If the qualified individual or the qualified individual's dependent chooses to select a QHP or the enrollee or enrollee's dependent chooses to select a new QHP, selects a QHP between 60 days before the loss of minimum essential coverage or the termination of coverage and 60 days after the loss of minimum essential coverage or the termination of coverage.

E. Enrollment in a QHP selected by a qualified individual, an enrollee, a qualified individual's dependent, or an enrollee's dependent during a special enrollment period for loss of minimum essential coverage or termination of coverage under §§A(1) and A(3)—(7) of this regulation will be effective on:

(1) The first day of the month following the loss of minimum essential coverage or termination of coverage if the Individual Exchange receives the QHP selection before the loss of minimum essential coverage or the coverage terminates; or

(2) The first day of the month after the Individual Exchange receives the QHP selection, if the Individual Exchange receives the QHP selection after the loss of minimum essential coverage or the coverage terminates.

F. The eligibility for a special enrollment period under §A(6) of this regulation shall only be available once per calendar year for the qualified individual and the qualified individual's dependent.

.13 Special Enrollment Periods—Change in Family Status

A. A qualified individual, an enrollee, a qualified individual's dependent and an enrollee's dependent are eligible for a special enrollment period for change in family status if the qualified individual or enrollee 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, an enrollee, a qualified individual's dependent and an enrollee's dependent are eligible for a special enrollment period for change in family status if the qualified individual or enrollee loses a dependent or is no longer considered a dependent through:

(1) Divorce;

(2) Legal separation; or

(3) Death.

C. Family status changes shall 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, the qualified individual, the enrollee, the qualified individual's dependent, or the enrollee's dependent shall select a QHP within 60 days of the change in family status under §§A and B of this regulation.

E. Enrollment in a QHP selected by a qualified individual, an enrollee, a qualified individual's dependent or an enrollee's dependent during a special enrollment period under this regulation shall be effective:

(1) For marriages, the first day of the month following the date that the Individual Exchange receives the QHP selection;

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

(3) In the case of death, the first day of the month following the date that the Individual Exchange receives the QHP selection; and

(4) For divorces or legal separation:

(a) The first day of the following month for QHP selections received by the Individual Exchange between the first and the fifteenth day of a month; or

(b) The first day of the second following month for QHP selections received by the Individual Exchange between the sixteenth and the last day of a month.

.14 Special Enrollment Period—Error, Misrepresentation, or Inaction.

A. Prior to January 1, 2018, a qualified individual or a qualified individual's dependent shall be eligible for the special enrollment period set forth in 45 CFR §155.420(c)(3) if the triggering event set forth in 45 CFR §155.420(d)(4) occurs.

B. Effective January 1, 2018, as evaluated and determined by the Individual Exchange, a qualified individual or a qualified individual's dependent is eligible for a special enrollment period when the individual or dependent's enrollment or non-enrollment in a QHP is:

(1) Unintentional, inadvertent, or erroneous; and

(2) The result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Individual Exchange, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.

C. Effective January 1, 2018, a qualified individual or a qualified individual's dependent shall notify the Individual Exchange of the alleged error, misrepresentation, or inaction by the later of:

(1) 30 days of the alleged error, misrepresentation, or inaction; or

(2) 30 days from when the qualified individual reasonably should have known about the alleged error, misrepresentation, or inaction.

D. Notification to the Individual Exchange under §C of this regulation shall be satisfied if the qualified individual or qualified individual's dependent provides notice:

(1) To an Individual Exchange-certified navigator, an Individual Exchange-authorized broker or an Individual Exchange-certified consolidated service center representative; and

(2) Via the modes of communication under Regulation .03B of this chapter.

E. Effective January 1, 2018, the length of the special enrollment period shall be 30 days from the date that the Individual Exchange notifies the qualified individual that the qualified individual or the qualified individual's dependent is eligible for a special enrollment period under this regulation.

F. The effective date of coverage for a qualified individual or the qualified individual's dependent who is determined eligible for a special enrollment period under this regulation and selects a QHP during the special enrollment period under §E of this regulation:

(1) Shall be a date determined by the Individual Exchange as appropriate based on the circumstances of the error, misrepresentation, or inaction;

(2) Shall be no earlier than the date the qualified individual's or qualified individual's dependent's coverage would have begun or continued, but for the error, misrepresentation, or inaction; and

(3) May be retroactive or prospective depending on the nature of the error, misrepresentation, or inaction.

.15 Special Enrollment Period—Misconduct.

A. Prior to January 1, 2018, a qualified individual or a qualified individual's dependent shall be eligible for the special enrollment period set forth in 45 CFR §155.420(c)(3) if the triggering event set forth in 45 CFR §155.420(d)(4) occurs.

B. Effective January 1, 2018, a qualified individual or qualified individual's dependent is eligible for a special enrollment period if:

(1) The Individual Exchange determines, in collaboration and coordination with the Maryland Insurance Administration, that as a result of misconduct on the part of a non-Exchange entity providing enrollment assistance or conducting enrollment activities the qualified individual or qualified individual's dependent:

(a) Was not enrolled in a QHP;

(b) Was not enrolled in the QHP selected by the qualified individual, enrollee or dependent; or

(c) Is eligible for, but is not receiving APTC or CSR; and

(2) The qualified individual or qualified individual's dependent notifies the Individual Exchange or the Maryland Insurance Administration of the alleged misconduct by the later of:

(a) 30 days of the misconduct; or

(b) 30 days of when the qualified individual reasonably should have known about the misconduct.

C. Misconduct under this regulation means the failure of an officer, employee, or agent of the Individual Exchange, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities.to comply with applicable standards set forth in COMAR 14.35 or other applicable State or federal laws as determined by the Individual Exchange.

D. Notification to the Individual Exchange under §B(2) of this regulation shall be satisfied if the qualified individual or qualified individual's dependent provides notice:

(1) To an Individual Exchange-certified navigator, an Individual Exchange-authorized broker or an Individual Exchange-certified consolidated service center representative; and

(2) Via the modes of communication under Regulation .03B of this chapter.

E. Notification to the Maryland Insurance Administration under §B(2) of this regulation shall be satisfied if the qualified individual or the qualified individual's dependent files a complaint with the Maryland Insurance Administration.

F. Effective January 1, 2018, the length of the SEP shall be 30 days from the date that the Individual Exchange notifies the qualified individual or the qualified individual's dependent that the qualified individual or the qualified individual's dependent is eligible for a special enrollment period under this regulation.

G. The effective date of coverage for a qualified individual or the qualified individual's dependent who is determined eligible for a special enrollment period under this regulation and selects a QHP during the special enrollment period under §F of this regulation:

(1) Shall be a date determined by the Individual Exchange as appropriate based on the circumstances of the misconduct;

(2) Shall be no earlier than the date the qualified individual's or the qualified individual's dependent's coverage would have begun or continued, but for the misconduct; and

(3) May be retroactive or prospective depending on the nature of the misconduct.

H. The Individual Exchange's determination that an individual is eligible for a special enrollment period under this regulation may be made prior to the completion of the Maryland Insurance Administration's review of the alleged misconduct.

.16 Special Enrollment Period—Violation of Material Provision.

A. Prior to January 1, 2018, a qualified individual or a qualified individual's dependent shall be eligible for the special enrollment period set forth in 45 CFR §155.420(c)(3) if the triggering event set forth in 45 CFR §155.420(d)(5) occurs.

B. Effective January 1, 2018, an enrollee or an enrollee's dependent is eligible for a special enrollment period if the enrollee or the enrollee's dependent:

(1) Demonstrates, as determined by the Individual Exchange in collaboration and coordination with the Maryland Insurance Administration, that the carrier of the QHP in which the enrollee or the enrollee's dependent is enrolled substantially violated a material provision of its contract in relation to the enrollee or the enrollee's dependent; and,

(2) Notifies the Exchange or the Maryland Insurance Administration of the alleged violation by the later of:

(a) 30 days of the violation; or

(b) 30 days of when the enrollee or the enrollee's dependent reasonably should have known about the violation.

C. Notification to the Individual Exchange under §B(2) of this regulation shall be satisfied if the enrollee or the enrollee's dependent provides notice:

(1) To an Individual Exchange-certified navigator, an Individual Exchange-authorized broker or an Individual Exchange-certified consolidated service center representative; and

(2) Via the modes of communication under Regulation .03B of this chapter.

D. Notification to the Maryland Insurance Administration under §B(2) of this regulation shall be satisfied if the enrollee or enrollee's dependent files a complaint with the Maryland Insurance Administration.

E. Effective January 1, 2018, the length of the special enrollment period shall be 30 days from the date that the Individual Exchange notifies the enrollee or the enrollee's dependent that the enrollee or enrollee's dependent is eligible for a special enrollment period under this regulation.

F. The effective date of coverage for an enrollee or an enrollee's dependent who is determined eligible for a special enrollment period under this regulation and selects a QHP during the SEP under §E of this regulation:

(1) Shall be a date determined by the Individual Exchange as appropriate based on the circumstances of the material violation;

(2) Shall be no earlier than the date the enrollee's or enrollee's dependent's coverage would have begun or continued, but for the material violation; and

(3) May be retroactive or prospective depending on the nature of the material violation.

G. The Individual Exchange's determination that an individual is eligible for a special enrollment period under this regulation may be made prior to the completion of the Maryland Insurance Administration's review of the alleged violation of a material provision of the contract in relation to the enrollee or the enrollee's dependent.

.17 Special Enrollment Period—Exceptional Circumstances.

A. Prior to January 1, 2018, a qualified individual or a qualified individual's dependent shall be eligible for the special enrollment period set forth in 45 CFR §155.420(c)(3) if the triggering event set forth in 45 CFR §155.420(d)(9) occurs.

B. Effective January 1, 2018, a qualified individual, enrollee, qualified individual's dependent, or enrollee's dependent is eligible for a special enrollment period if:

(1) The Individual Exchange determines that, at the time of the qualified individual, enrollee, qualified individual's dependent or enrollee's dependent's application for coverage, the individual experienced exceptional circumstances that prevented the qualified individual, the enrollee, the qualified individual's dependent or the enrollee's dependent from enrolling during open enrollment or a special enrollment period, if the individual was determined eligible for the special enrollment period by the Individual Exchange; and

(2) The qualified individual, the enrollee, the qualified individual's dependent, or the enrollee's dependent notifies the Exchange within 30 days of the exceptional circumstances.

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

(1) A serious medical condition, such as an unexpected hospitalization or temporary cognitive disability;

(2) Domestic abuse or violence;

(3) Spousal abandonment;

(4) A natural disaster, such as an earthquake, a massive flooding, or a hurricane; or

(5) A significant life event resulting in lack of access to the qualified individual's or enrollee's Individual Exchange application or account and the qualified individual, the enrollee, the qualified individual's dependent or the enrollee's dependent has experienced a change in situation or status that now requires that the qualified individual, the enrollee, the qualified individual's dependent or the enrollee's dependent obtain minimum essential coverage.

D. Notification to the Individual Exchange under §B(2) of this regulation shall be satisfied if the qualified individual, the enrollee, the qualified individual's dependent or the enrollee's dependent provides notice:

(1) To an Individual Exchange-certified navigator, an Individual Exchange-authorized broker or an Individual Exchange-certified consolidated service center representative; and

(2) Via the modes of communication under Regulation .03B of this chapter.

E. Effective January 1, 2018,, the length of the special enrollment period shall be 30 days from the date that the Individual Exchange notifies the qualified individual, enrollee, the qualified individual's dependent, or the enrollee's dependent that the qualified individual, the enrollee, the qualified individual's dependent, or the enrollee's dependent is eligible for a special enrollment period under this regulation.

F. The effective date of coverage for a qualified individual, an enrollee, a qualified individual's dependent, or an enrollee's dependent who is determined eligible for a special enrollment period under this regulation and selects a QHP during the special enrollment period under §E of this regulation:

(1) Shall be a date determined by the Individual Exchange as appropriate based on the circumstances of the qualified individual, the enrollee, the qualified individual's dependent, or the enrollee's dependent's exceptional circumstances;

(2) Shall be no earlier than the date the qualified individual's, the enrollee's, the qualified individual's dependent's, or the enrollee's dependent's coverage would have begun or continued, but for the exceptional circumstance; and

(3) May be retroactive or prospective depending on the nature of the exceptional circumstance.

.18 Special Enrollment Period—Permanent Move.

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

(1) Gains access to a new QHP as a result of a permanent move;

(2) Was enrolled in minimum essential coverage for one or more days in the 60 days prior to the move, unless the qualified individual enrollee, qualified individual's dependent or enrollee's dependent:

(a) Is moving from a foreign country or a United States territory;

(b) Is moving from a state that did not expand Medicaid or MCHP eligibility set forth in §2001 of the ACA and the individual was not eligible for APTC or CSR in the individual's previous state of residence because the individual's household income was below 100% of the FPL; or

(c) Is leaving incarceration, except if the individual was incarcerated pending disposition; and

(3) Notifies the Individual Exchange within 60 days from the date of the permanent move that the qualified individual, the enrollee, the qualified individual's dependent or the enrollee's dependent has gained access to a new QHP as a result of that move.

B. A permanent move does not include:

(1) A short-term or temporary move where the qualified individual, the enrollee, the qualified individual's dependent or the enrollee's dependent does not intend to remain in the individual's new location; or

(2) A move solely for the purposes of obtaining medical treatment.

C. A qualified individual, an enrollee, a qualified individual's dependent, or an enrollee's dependent may select a qualified health plan within 60 of the date of the permanent move if the individual is otherwise eligible for the special enrollment period.

D. Effective January 1, 2017, a qualified individual, an enrollee, a qualified individual's dependent, or an enrollee's dependent may also select a QHP and notify the Individual Exchange 60 days before the permanent move date if the individual is otherwise eligible for the special enrollment period.

E. The effective date of coverage for a qualified individual, an enrollee, a qualified individual's dependent or an enrollee's dependent who is determined eligible for the special enrollment period under this regulation and selects enrollment in a QHP during the special enrollment period under §C of this regulation:

(1) Prior to January 1, 2017, shall be:

(a) The first day of the following month for QHP selections received by the Individual Exchange between the first and the fifteenth day of a month; or

(b) The first day of the second following month for QHP selections received by the Individual Exchange between the sixteenth and the last day of a month; and

(2) Effective January 1, 2017 for QHP selections received by the Individual Exchange prior to the permanent move or on the date of the move, shall be the first day of the month following the permanent move.

.19 Special Enrollment Period—Other.

A. An enrollee or an enrollee's dependent is eligible for a special enrollment period if the enrollee or the enrollee's dependent is determined newly eligible or ineligible for APTC or has a change in eligibility for CSR.

B. A qualified individual who is an Indian may enroll in a QHP or change from one QHP to another, no more than once per month.

C. A qualified individual or a qualified individual's dependent is eligible for a special enrollment period if the qualified individual or the qualified individual's dependent who was not previously a U.S. citizen, U.S. national, or lawfully present in the U.S. becomes a U.S citizen, U.S. national, or lawfully present in the U.S.

D. A qualified individual and a qualified individual's dependent are eligible for a special enrollment period if the qualified individual receives a certificate of exemption under Regulation .20 of this chapter for a hardship based on the eligibility standards set forth in 45 CFR §155.605(g)(1) for a month or months during the coverage year, and based on the circumstances of the hardship attested to, the qualified individual is no longer eligible for a hardship exemption within a coverage year but outside of an open enrollment period.

E. A qualified individual and a qualified individual's dependent are eligible for a special enrollment period if a qualified individual with a certificate of exemption under Regulation .20 of this chapter reports a change regarding the eligibility standards for an exemption, as set forth in 45 CFR §155.620(b), the change resulting from a redetermination is implemented, and the qualified individual or the qualified individual's dependent is no longer eligible for an exemption.

F. A qualified individual, an enrollee, a qualified individual's dependent, or an enrollee's dependent has 60 days from the date of the change in circumstance creating eligibility for a special enrollment period under this regulation to notify the Individual Exchange of the change in circumstance and select a QHP.

G. The effective date of coverage for a qualified individual, an enrollee, a qualified individual's dependent or an enrollee's dependent who is determined eligible for a special enrollment period under this regulation is effective:

(1) The first day of the following month, for QHP selections received by the Individual Exchange between the first and the fifteenth day of a month; or

(2) The first day of the second following month, for QHP selections received by the Individual Exchange between the sixteenth and the last day of a month.

.20 Exemptions.

A. As set forth in 45 CFR §155.625(b), the Individual 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 set forth in Subpart G of Part 155, Title of Public Welfare; and

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

.21 Authorized Representative.

An applicant or enrollee in the Individual Exchange may designate an individual or an organization to act as the applicant or enrollee's representative as set forth in COMAR 14.35.11.14.