

Health Connector Policy: Mid-Year Life Events or Qualifying Events

Policy #: NG-5	Effective date: 7/23/2024
Category: Eligibility	Date revised: 7/23/2024
Approved by: Andrew Egan	Date reviewed: 7/23/2024

This policy applies to all non-group health and dental products.

The Health Connector will allow unenrolled qualified individuals, Health Connector enrollees, and any dependent(s) to enroll in or make changes to their plan selection during a plan year within 60 days of any of the below listed qualifying events (unless otherwise noted). Certain types of qualifying events are applicable to unenrolled qualified individuals, Health Connector enrollees and dependents, while other qualifying events are only applicable to Health Connector enrollees.

Although individuals and their dependent(s) can enroll in a Health Connector dental plan at any point during the year, dental plan enrollees must experience one of the qualifying events listed below to switch plans without a lock-out period. Additionally, individuals enrolling in a dental plan after a qualifying event may be subject to a waiting period before being able to use certain dental benefits. Lock-out periods and waiting periods do not apply to individuals seeking health coverage after a qualifying event.¹

Qualifying events applicable to a qualified individual, enrollee, or their dependent(s) triggering the loss of minimum essential coverage (as defined by § 5000A of the Internal Revenue Code) are provided in the list below. Such events are qualifying only if the reason for the loss is other than failure to pay premiums, including failure to pay COBRA premiums prior to expiration of COBRA coverage, or situations allowing for a rescission as specified in 45 CFR § 147.128, such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan.

Qualifying events triggered by the loss of Minimum Essential Coverage include:

- Losing employer sponsored insurance due to death of the subscriber employee, reduction of the hours of employment, and termination of employment (regardless of whether the individual is eligible for or elects COBRA).
- Losing coverage through the subscriber's plan due to subscriber's Medicare eligibility.

- Losing coverage due to death, legal separation, divorce, or cessation of dependent status.
- Losing access to coverage due to no longer residing, living, or working in the issuer's service area.
- Losing access to coverage due to incurring a claim that would meet or exceed a lifetime limit on all benefits.
- Losing access to coverage because the plan is no longer offering any benefits to the class of similarly situated individuals that includes the individual or a plan that was decertified by the Health Connector.
- Losing access to coverage due to exhaustion of COBRA coverage.
- Losing access to coverage due to the expiration of a non-calendar year group health plan, including an Individual Coverage Health Reimbursement Arrangement (ICHRA), individual health insurance coverage, or Qualified Small Employer Health Reimbursement Arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code). This qualifying event is valid if there is an option to renew such coverage.
- Losing eligibility for public qualifying minimum essential coverage, such as Medicare or Medicaid, or affordable employer-sponsored coverage that meets minimum value standards.

Qualifying events applicable to a qualified individual, enrollee, or their dependent(s) include:

- Gaining or becoming a dependent through marriage, birth, adoption, placement for adoption, placement in foster care, or court-ordered care of a child.
- Losing pregnancy-related coverage or medically needy coverage once per year under the Social Security Act.²
- Gaining access to new Health Connector health or dental plans as the result of a permanent move, which includes release from incarceration.
- Gaining or maintaining status as American Indian or Native Alaskan as defined by section 4 of the Indian Self-Determination and Education Assistance Act. See, 25 U.S.C. § 450b(d).
- Becoming newly eligible for Health Connector enrollment due to satisfying requirements for citizenship, status as a national or lawful presence.
- Unintentional, inadvertent, or erroneous enrollment or no enrollment in a health or dental plan due to the error, misrepresentation, misconduct, or inaction of an officer, employee or agent, of the Health Connector, the U.S. Department of Health and Human Services (HHS), or non-Exchange entities providing enrollment activities, as determined by the Health Connector. An error would include incorrect calculation of Advance Premium Tax Credits (APTCs) or Cost Sharing Reductions (CSRs).³
- Demonstrating to the Health Connector, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances.³
- Mistakenly purchasing coverage that is not comprehensive due to deceptive marketing practices.³
- Becoming newly eligible for APTCs based on a finding that the individual will no longer be eligible for affordable employer-sponsored coverage meeting minimum value standards in the next 60 days provided that the individual is permitted to terminate existing coverage.⁴

- Experiencing domestic abuse or spousal abandonment. Victims applying for financial assistance and married to the spouse who abused or abandoned them must attest on their application that they expect to file taxes as “Married Filing Separately” to be considered for APTCs.
- Obtaining an approved waiver from the Office of Patient Protection.
- Gaining access to or newly being provided an ICHRA or QSEHRA through an employer. A qualified individual, enrollee, or their dependent will have 60 days before the start of the ICHRA or QSEHRA to enroll, unless the ICHRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year.⁵
- Becoming eligible for a Health Connector health plan through the Simple Sign-Up program.
- Complete cessation of employer or government subsidies for COBRA continuation coverage.

Qualifying events applicable to a qualified enrollee or their dependent(s) include:

- Adequately demonstrating to the Health Connector that the health or dental plan in which the individual is enrolled substantially violated a material provision of its contract with the enrollee.
- Becoming newly eligible or newly ineligible for APTCs.⁶

Reporting requirement: Mid-year life event(s) must be reported to the Health Connector within 60 days of the event. The Health Connector may require documents proving that the qualified individual, enrollee or their dependent(s) meets one or more of the above criteria. Loss of minimum essential coverage and permanent move can be reported 60 days prior to the event.

Effective dates: Changes to enrollments will be effective in accordance with NG-7: *Enrollment in Individual/Family Plan* except in the case of birth, adoption or placement for adoption or foster care for which coverage will be effective on the date of birth, adoption, or placement for adoption or foster care or the first day of the month following the date of birth, adoption, or placement for adoption or foster care. Any APTCs or CSRs will only become effective on the first day of the first full month during which the individual is enrolled in a health or dental plan and not enrolled in other minimum essential coverage.

Allowable actions: Qualified individuals, enrollees, or their dependents who experience a qualifying life event may be added to an existing plan, change enrollment to another plan or enroll in a separate plan for new enrollees. Households may be limited in the plans they can enroll in following a qualifying event based on metallic tier or program eligibility.

Qualifying events applicable to ConnectorCare products only:

In addition to the mid-year life events or qualifying events described above, ConnectorCare enrollees, qualified individuals, or their dependents may transfer from a ConnectorCare health plan or enroll in a ConnectorCare health plan outside of the Open Enrollment period during a special enrollment period established by the Health Connector if:

- A qualified individual is determined newly eligible for a ConnectorCare plan.
- A qualified enrollee changes ConnectorCare Plan Types due to a change in income.
- A qualified enrollee is approved for a Hardship Waiver in accordance with Health Connector regulations at 956 CMR 12.11.
- A qualified enrollee's Hardship Waiver period has ended.

Qualified individuals and enrollees will have sixty (60) days to enroll in a health plan from the date of one of the events described above. A ConnectorCare enrollee or qualified individual may change to a ConnectorCare plan if not already enrolled in one or change to a different ConnectorCare Plan Type based on income.

Lastly, qualified individuals, enrollees, or their dependents, who are eligible for APTCs and whose household income does not exceed 150 percent of the Federal Poverty Level (FPL) have an opportunity to enroll or change plans one time per month when the applicable percentage used in calculating APTC amounts is set to zero.⁷

Annual Open Enrollment Period

A qualified individual, enrollee, or dependent will be able to enroll in coverage without experiencing a qualifying event or make changes to a plan selection for the upcoming year during the annual open enrollment period each year.⁸

¹Please reference the policy NG-10: Termination of Coverage – Voluntary.

²As described in §1902(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX), or (a)(10)(C)) of the Social Security Act.

³To find out more information about how to access these qualifying events, please contact Health Connector Customer Service.

⁴Please reference the policies NG-2: Eligibility for Federal and State Financial Support for Individual/Family Plan and NG-7: Enrollment in Individual/Family Plan.

⁵45 CFR § 155.420(c)(3). ICHRAs or QSEHRAs are not required to give at least 90 days' notice before the beginning of the plan year for new hires during the plan year, for employees of a business formed less than 120 days prior to the plan start date, nor, in the case of ICHRAs, for employees who become newly eligible for the ICHRA during the plan year, including as a result of reclassification.

⁶Please reference the policy NG-2: Eligibility for Federal and State Financial Support for Individual/Family Plan.

⁷45 CFR § 155.420(d)(16).

⁸Please reference the policy NG-7: Enrollment in Individual/Family Plan for additional information regarding Open Enrollment.