Health Connector Policy:
Redetermination During the Benefit Year

Policy #: **NG-2**	Date revised: **11/4/2014**
Category: **Eligibility**	Effective date: **1/1/2015**
Approved by: **Ed DeAngelo**	

Applicable to all Non-Group products (Qualified Health Plan or QHP/Qualified Dental Plan or QDP)

The Health Connector is required to redetermine eligibility for enrollment in a Health Connector Plan (Qualified Health Plan or QHP) / Health Connector Dental Plan (Qualified Dental Plan or QDP) and any state or federal assistance (if applicable) for an enrollee and his/her dependent(s) based upon a verified change to any eligibility criteria.[1] This includes information reported by the enrollee or obtained by the Health Connector through a data match during the benefit year. A change is considered verified if it has been confirmed by the enrollee and either the information provided is consistent with the records of the Health Connector (i.e. the Health Connector was able to confirm the change by matching with electronic data sources or the enrollee has provided documentation).

An enrollee and his/her dependent(s) must report any changes that impact eligibility within 30 days of the event. The enrollee must report changes related to:

a. Change in family size or composition due to birth, adoption, placement for adoption, marriage, divorce, death, etc.;
b. Change in residency;
c. Change in citizenship, nationality, or lawful presence;
d. Change in Indian status (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. §450b(d));[2]
e. Change in incarceration status;

Only individuals who requested an eligibility determination for federal and state financial support are required to report changes related to: [3]

a. Eligibility determination for Medicare, Medicaid, or CHIP;
b. Any change in income;
c. Change in job status, including any change in eligibility for employer-sponsored insurance

If the Health Connector identifies updated information through data matching, the Health Connector will notify the enrollee and provide him/her 30 days to respond to the request to verify.

1. If the enrollee confirms the information in the notice, his/her eligibility will be updated in accordance with the effective dates below.

2. If the enrollee provides different information, the Health Connector will verify the information provided by the enrollee and update eligibility in accordance with the effective dates below.
3. If the enrollee does not respond to the notice, the Health Connector will update eligibility using the information collected via data matching in accordance with the effective dates below unless such data matching is related to income, family size, or family composition. If the enrollee does not respond to data matching regarding income, family size, or family composition, no change will be made to eligibility.

Verified changes will be effective as follows:

1. Coverage changes will be effective as of the first day of the month following the event if such change is reported prior to the 23rd calendar day of the month. If the change is not reported prior to the 23rd calendar day of the month, coverage will be effective the first of the second month. Except,
   a. In the case of birth, adoption or placement for adoption or foster care, coverage changes will be effective either on the date of birth, adoption, or placement for adoption or foster care, or on the first of the month following the date of birth, adoption or placement for adoption or foster care;
   b. If the eligibility determination results in an enrollee or any of his/her dependent(s) being ineligible to continue enrollment in a non-group product through the Health Connector, the enrollee may maintain his/her enrollment for a full month after the month in which the determination notice is sent.
2. Any new premium tax credit (Advance Premium Tax Credit or APTC) /cost sharing reduction (CSR) will only become effective on the first day of the first full month during which the enrollee is enrolled in a non-group product and not enrolled in other minimum essential coverage. If the eligibility determination results in an enrollee or any of his/her dependent(s) being ineligible for APTCs/CSRs or to continue enrollment in a non-group product through the Health Connector, APTCs/CSRs will be terminated.

[1] *Please reference the policies Eligibility for Individuals/Family Plan (NG-1A), Eligibility for Federal and State Financial Support for Individual/Family Plan (NG-1B), Special Rules for American Indians/Alaskan Natives (Indians) (NG-1C), Eligibility for Catastrophic Plans (NG-1D)*

[2] *Please reference the policy Special Rules for American Indians/Alaska Natives (NG-1C)*

[3] *If the enrollee did not request an eligibility determination for insurance affordability programs, even if they may be eligible for one by virtue of the change, s/he is not required to report changes regarding these eligibility criteria. Please reference the policy Eligibility for Federal and State Financial Support for Individual/Family Plan (NG-1B)*