

Qualifying Midyear Events (QMEs) - General

What are Qualifying Midyear Events (QMEs)?

In general, cafeteria plan elections are irrevocable for the duration of the plan year. However, QMEs are specific life events that allow health plan participants to make mid-plan-year election changes. Because cafeteria plans allow for pre-tax premium contributions, these events are limited to those defined by the Internal Revenue Service (IRS). However, while cafeteria plans may not allow election changes that are not allowed by the IRS, they may further limit those IRS events within their specific plan provisions. The State Health Benefits Program allows changes based on all QMEs defined by the IRS. (NOTE: While retiree group participants do not pay their premiums on a pre-tax basis, for consistency purposes and to protect the plans from adverse selection, they are held to the same QME rules as active employees.)

To exercise midyear election changes based on QMEs, enrollees/subscribers (not covered family members) must submit the change request within 60 calendar days of the event. With the exception of certain HIPAA Special Enrollments and all loss of eligibility events, addressed later in this section, the election change will be effective the first of the month after the notification/request is submitted.

The countdown for the 60-day window begins on the day of the qualifying event. Failure to make the request within the window will result in loss of the right to make the midyear election change and delaying the change until open enrollment. However, once the election change takes effect, it is binding and cannot be changed until open enrollment or upon the occurrence of another consistent qualifying event.

Exceptions to the 60-day enrollment window requirement:

- Adding family members to an existing family contract/membership level allows for adding a family member prospectively at any time —see the ***Adding Family Members to an Existing Family Contract*** section for more information.
- Loss of Eligibility Events requiring termination of coverage at the end of the month during which the loss of eligibility occurs—this applies to events that result in loss of eligibility for the program. The change must be submitted within the 60-day window, but coverage will terminate at the end of the month during which the event occurred. Failure to report the event within the 60-day window will not preclude termination of coverage retroactive to the correct termination date; however, failure to do so will result in maintaining the premium at the existing level (no reduction in membership, if applicable) until the next open enrollment or consistent qualifying event that would allow the reduction.

Following are the events that allow midyear changes. Note that the change must be on account of and consistent with the event. (For example, divorce would be consistent with dropping a spouse/stepchildren; marriage would be consistent with adding a spouse/stepchildren). Documentation must be provided to support the event and any relationship required to gain eligibility:

- Birth, Adoption, or Placement for Adoption*
- Child Covered under Your Health Plan Lost Eligibility

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- Death of Child
- Death of Spouse
- Divorce
- Employment Change – Beginning a Leave Without Pay
- Employment Change – Full-time to Part-time
- Employment Change – Part-time to Full-time
- Employment Change – Returning from a Leave Without Pay
- Enroll in a Qualified Health plan through the Marketplace Exchange under the Affordable Care Act (ACA)
- Gained Eligibility under Medicare or Medicaid
- HIPAA Special Enrollment
- Judgment, Decree, or Order to Add Child
- Judgment, Decree, or Order to Remove Child
- Lost Eligibility under Governmental Plan
- Lost Eligibility under Medicare or Medicaid
- Marriage
- Move Affecting Eligibility for Health Care Plan
- Other Employer's Open Enrollment or Plan Change
- Spouse or Child Gained Eligibility under Their Employer's Plan
- Spouse or Child Lost Eligibility under Their Employer's Plan

* Placement, or being placed, for adoption means the assumption and retention of a legal obligation for total or partial support of a child by a person with whom the child has been placed in anticipation of the child's adoption. The child's placement for adoption with such person ends upon the termination of such legal obligation. An agreement for full or partial support of a child will constitute a legal obligation only if the obligation is enforceable in a court of competent jurisdiction, which depends on the facts and circumstances associated with the agreement. The employee must be party to the support agreement and the agreement must extend beyond the obligation to provide Medical coverage.

What is a HIPAA Special Enrollment?

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, under a *HIPAA Special Enrollment* you may be able to enroll yourself and your dependents in this plan if:

- you or your dependents lose eligibility for that other coverage (or if the employer stopped contributing towards your or your dependents' other coverage). However, you must request enrollment within 60 days of the date your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).
- you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and all eligible dependents. However, you must request enrollment within 60 days of the marriage, birth, adoption or placement for adoption.
- you or your dependent lose coverage in Medicaid or the State Children's Health Insurance Program (SCHIP) and you request coverage under the plan within 60 days of the time your coverage ends; or

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- you or your dependent becomes eligible for a Medicaid or SCHIP premium assistance subsidy and you request coverage under the plan within 60 days of the date your eligibility is determined.

What are the HIPAA Special Enrollment Provisions for Birth, Adoption or Placement for Adoption

An exception to prospective changes is health plan coverage for newborns, adopted children, and those children placed for adoption. In these events, health plan coverage will be retroactive to the date of birth, adoption or placement for adoption.

However, in some cases, employees or retiree group participants may make the health plan coverage election on a prospective basis. If the employee or retiree group participant can provide documentation of coverage for the month of birth, adoption or placement for adoption, then their coverage in the State's plan can be effective the first of the month following receipt of the enrollment action.