

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105

██████████ 2016
Signature Confirmation

Client ID # ██████████
Application # ██████████
Hearing Request # 788520

NOTICE OF DECISION
PARTY

██████████
██████████
██████████

PROCEDURAL BACKGROUND

On ██████████ 2016, the Health Insurance Exchange Access Health CT (“AHCT”) sent ██████████ (the “Appellant”) a notice denying her application for Advanced Premium Tax Credit (“APTC”).

On ██████████ 2016, The Appellant requested a hearing to contest the denial of the APTC.

On ██████████ 2016, the Office of legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling the administrative hearing for ██████████ 2016.

On ██████████ 2016, in accordance with sections 17b-60, 17b-264 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, chapter 45 Code of Federal Regulations (“CFR”) §§ 155.505(b) and 155.510 and/or 42 CFR § 457.1130, OLCRAH held an administrative hearing. The following individuals were present at the hearing:

██████████ Appellant
Krystal Sherman-Davis, Health Insurance Exchange Access Health CT Representative
Veronica King, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Access Health CT correctly denied the Appellant's application for APTC.

FINDINGS OF FACT

1. On [REDACTED] 2016, the Appellant applied for a Qualified Health Plan ("QHP") through the State of Connecticut Health Insurance Exchange via telephone. (Exhibit 1: Application ID [REDACTED] [REDACTED]/16 and Hearing Record)
2. The Appellant is 54 years old, lives alone and files taxes as single, head of household with no dependents. (Exhibit 1)
3. The Appellant self-declared \$1,881.25 monthly and \$22,000.00 yearly in income. (Exhibit 1)
4. On [REDACTED] 2016, AHCT sent the Appellant, denying Medicaid Husky D over income and stating that the Appellant did not qualify to buy a QHP with APTC through the State of Connecticut Health Insurance Exchange because she did not have a qualifying event in order to enroll outside of the annual open enrollment period. (Exhibit 3: Health Care Application Notice, [REDACTED]/16 and Hearing Record)
5. The Appellant was a recipient of Medicaid Husky D healthcare insurance. On [REDACTED] 2016, the Appellant's Husky D insurance ended and she became eligible to purchase a QHP with APTC, however the Appellant did not make any plan selections. (Hearing Record)
6. The open enrollment for 2016 Qualified Health Insurance through the State of Connecticut Health Insurance Exchange started on [REDACTED] 2015 and ended on [REDACTED] 2016. (Hearing Record)
7. On [REDACTED] 2016, AHCT spoke with the Appellant and verified that currently she does not have any qualifying events that would allow her to enroll outside of Open Enrollment. (Hearing Record)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes (“CGS”) provides for acceptance of federal grants for medical assistance. The Commissioner of Social Services is authorized to take advantage of the medical assistance programs provided in Title XIX, entitled "Grants to States for Medical Assistance Programs", contained in the Social Security Amendments of 1965 and may administer the same in accordance with the requirements provided therein, including the waiving, with respect to the amount paid for medical care, of provisions concerning recovery from beneficiaries or their estates, charges and recoveries against legally liable relatives, and liens against property of beneficiaries.
2. Section 17b-264 of the CGS provides for the extension of other public assistance provisions. All of the provisions of sections 17b-22, 17b-75 to 17b-77, inclusive, 17b-79 to 17b-83, inclusive, 17b-85 to 17b-103, inclusive, and 17b-600 to 17b-604, inclusive, are extended to the medical assistance program except such provisions as are inconsistent with federal law and regulations governing Title XIX of the Social Security Amendments of 1965 and sections 17b-260 to 17b-262, inclusive, 17b-264 to 17b-285, inclusive, and 17b-357 to 17b-361, inclusive.
3. Title 45 of the Code of Federal Regulations (“CFR”) § 155.505(c)(1) provides that Exchange eligibility appeals may be conducted by a State Exchange appeals entity or an eligible entity described in paragraph (d) of this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.
4. 45 CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).
5. 45 CFR § 155.110(a)(2) provides that the State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are: the State Medicaid agency, or any other State agency that meets the qualification of paragraph (a)(1) of this section.
6. 45 CFR § 155.310 (K) (1)(2)(3) pertains to an incomplete application. If an application filer submits an application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for insurance affordability programs, if applicable, the Exchange must –
 - (1) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; and
 - (2) provide the applicant with a period of no less than 10 days and no more than 90 days from the date on which the notice described in paragraph (k)(1) of this

section is sent to the applicant to provide the information needed to complete the application to the Exchange. And

(3) During the period described in paragraph (k)(2) of this section, the Exchange must not proceed with an applicant's eligibility determination or provide advance payments of the premium tax credit or cost sharing reductions, unless an application filer has provided sufficient information to determine his or her eligibility for enrollment in a QHP through the Exchange, in which case the Exchange must make such a determination for enrollment in a QHP.

7. 45 CFR§ 155.420 (d) in part provides that Exchange must allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from one QHP to another if one of the following triggering events occur:

(1) The qualified individual or his or her dependent either:

- (i) Loses minimum essential coverage. The date of the loss of coverage is the last day the consumer would have coverage under his or her previous plan or coverage.
- (ii) Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage. The date of the loss of coverage is the last day of the plan or policy year;
- (iii) Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)). The date of the loss of coverage is the last day the consumer would have pregnancy-related coverage; or
- (iv) Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.

(2)(i) The Qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.

(ii) At the option of the Exchange, the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies

8. AHCT correctly determined that the Appellant did not have qualifying event to enroll in 2016 health insurance coverage outside of the annual open enrollment period for QHP with APTC through the State of Connecticut Health Insurance Exchange.

DECISION

The Appellant's Appeal is **DENIED**.

Veronica King

Veronica King
Hearing Officer

Pc: Judy Boucher, Health Insurance Exchange Access Health CT

APTC/CSR

Right to Appeal

For APTC or CSR eligibility determinations, the Appellant has the right to appeal to the United States Department of Health and Human Services (HHS) within 30 days of the date of this decision. To obtain an Appeal Request Form, go to <https://www.healthcare.gov/can-i-appeal-a-marketplace-decision/> or call 1-800-318-2596 (TTY: 1-855-889-4325). HHS will let the Appellant know what it decides within 90 days of the appeal request. There is no right to judicial review of the decision by HHS.

There is no right to request reconsideration for denials or reductions of Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (CSR).

MEDICAID AND CHIP

Right to Request Reconsideration

For denials or reductions of MAGI Medicaid and CHIP, the appellant has the right to file a written reconsideration request within 15 days of the mailing date of the decision on the grounds there was an error of fact or law, new evidence has been discovered or other good cause exists. If the request for reconsideration is granted, the appellant will be notified within 25 days of the request date. No response within 25 days means that the request for reconsideration has been denied. The right to request a reconsideration is based on §4-181a(a) of the Connecticut General Statutes.

Reconsideration requests should include specific grounds for the request: for example, indicate what error of fact or law, what new evidence, or what other good cause exists.

Reconsideration requests should be sent to: Department of Social Services, Director, Office of Legal Counsel, Regulations, and Administrative Hearings, 55 Farmington Avenue, Hartford, CT 06105-3725.

There is no right to request reconsideration for denials or reductions of Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (CSR).

Right to Appeal

For denials, terminations or reductions of MAGI Medicaid and CHIP eligibility, the appellant has the right to appeal this decision to Superior Court within 45 days of the mailing of this decision, or 45 days after the agency denies a petition for reconsideration of this decision, provided that the petition for reconsideration was filed timely with the Department. The right to appeal is based on §4-183 of the Connecticut General Statutes. To appeal, a petition must be filed at Superior Court. A copy of the petition must be served upon the Office of the Attorney General, 55 Elm Street, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105. A copy of the petition must also be served on all parties to the hearing.

The **45** day appeal period may be extended in certain instances if there is good cause. The extension request must be filed with the Commissioner of the Department of Social Services in writing no later than **90** days from the mailing of the decision. Good cause circumstances are evaluated by the Commissioner or his designee in accordance with §17b-61 of the Connecticut General Statutes. The Agency's decision to grant an extension is final and is not subject to review or appeal.

The appeal should be filed with the clerk of the Superior Court in the Judicial District of New Britain or the Judicial District in which the appellant resides.

