**STATE OF CONNECTICUT**
**DEPARTMENT OF SOCIAL SERVICES**
**OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS**
**55 FARMINGTON AVE.**
**HARTFORD, CT 06105-3725**

[redacted] **2017**
**Signature Confirmation**

**Client ID #** [redacted]
**Request # 102569**

## NOTICE OF DECISION

## PARTY

[redacted]

## PROCEDURAL BACKGROUND

On [redacted] 2017, the Health Insurance Exchange, Access Health CT ("AHCT") sent [redacted] (the "Appellant") a notice of action discontinuing his Husky D assistance.

On [redacted] 2017, the Appellant requested an administrative hearing to contest the AHCT's decision to discontinue such benefits.

On [redacted] 2017, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, in accordance with sections 17b-60, 17b-264 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, Title 45 Code of Federal Regulations ("CFR") §§ 155.505(b) and 155.510 and/or 42 CFR § 457.113, OLCRAH held an administrative hearing by telephone.

The following individuals called in for the hearing:

[redacted] Appellant
Sabrina Solis, AHCT Representative
Christopher Turner, Hearing Officer

## STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the Appellant's healthcare coverage under the Medicaid/Husky D program.

## FINDINGS OF FACT

1. On [redacted] 2017, the Appellant submitted an online Medicaid/Husky D change application form. (Exhibit 1: Application form)

2. The Appellant's household consists of one person. (Exhibit 1: Application form)

3. The Appellant is 30 years old (DOB [redacted]/87). (Exhibit 1)

4. The Appellant receives Social Security Disability benefits of $1,095.00 per month. (Hearing summary; Appellant's testimony)

5. The Appellant receives Medicare Part A and Part D coverage, which was effective [redacted] 2017. (Appellant's testimony)

6. The Appellant does not receive Medicare Part B coverage. (Appellant's testimony)

7. On [redacted] 2017, AHCT issued the Appellant a health care coverage renewal decision notice. The notice indicated the Appellant's Medicaid/Husky D assistance would end [redacted]/17 due to his Medicare coverage. (Exhibit 2: Discontinuance notice dated [redacted]/17)

## CONCLUSIONS OF LAW

1. Connecticut General Statutes § 17b-260 provides that 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. Connecticut General Statutes §17b-264 provides that 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. Uniform Policy Manual ("UPM") §1570.10 (A) provides, except in situations described below, the Department mails or gives adequate notice at least ten days prior to the date of the intended action if the Department intends to: 1. Discontinue, terminate, suspend or reduce benefits; or 2. Change the manner or form of payment for programs.

   UPM §1570.10 (B) provides exceptions to timely notice requirements. 1. The Department mails an adequate notice no later than the date of the action if the action is based on any of the following circumstances: a. the Department has factual information that all members of the assistance unit have died; or b. the Department receives a clear, written statement signed by the assistance unit stating that: (1) the unit no longer wishes to receive benefits; or (2) the unit is giving the Department information which requires that the Department terminate or reduce benefits, and that the unit understands that this must be the result of supplying that information; or c. the assistance unit is required to submit monthly reports and the unit either: (1) furnishes information which requires that the Department reduce or discontinue benefits; or (2) fails to complete a timely monthly report without good cause; or d. the affected individual has been admitted to or committed to an institution, and the individual is not eligible for assistance while living there; or e. the assistance unit's whereabouts are unknown and the post office returns departmental mail directed to the unit indicating no forwarding address; or f. the Department verifies that the assistance unit has been granted benefits under the same program in another state .

4. The Appellant received proper notification.

5. 45 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) or this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.

6. 45 CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

7. 45 CFR § 155.110(a) 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: (1) An entity: (i) Incorporated under, and subject to the laws of, one or more States;(ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and(iii) Is not a health insurance issuer or treated as a health insurance issuer under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or (2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

8. 45 CFR § 156.20 defines essential health benefits package or EHB package as the scope of covered benefits and associated limits of a health plan offered by an issuer that provides at least the ten statutory categories of benefits, as described in §156.110(a) of this subchapter; provides the benefits in the manner described in §156.115 of this subchapter; limits cost sharing for such coverage as described in §156.130; and subject to offering catastrophic plans as described in section 1302(e) of the Affordable Care Act, provides distinct levels of coverage as described in §156.140 of this subchapter.

9. 26 CFR § 1.5000A-2(a) provides that in general minimum essential coverage means coverage under a government-sponsored program (described in paragraph (b) of this section), an eligible employer-sponsored plan (described in paragraph (c) of this section), a plan in the individual market (described in paragraph (d) of this section), a grandfathered health plan (described in paragraph (e) of this section), or health benefits coverage (described in paragraph (f) of this section). Minimum essential coverage does not include coverage described in paragraph (g) of this section. All terms defined in this section apply for purposes of this section and § 1.5000A-1 and §§ 1.5000A-3 through 1.5000A-5.

10. 26 CFR § 1.5000A-2(b)(1)(i) provides that in general except as provided in paragraph (2), government-sponsored program means any of the following: Medicare. The Medicare program under part A of Title XVIII of the Social Security Act (42 U.S.C. 1395c and following sections).

11. 42 CFR § 435.2(b) provides that this part sets forth, for the 50 states, the District of Columbia, the Northern Mariana Islands, and American Samoa the mandatory and optional groups of individual to whom Medicaid is provided under a State plan.

12. 42 CFR § 435.119(b) provides that effective January 1, 2014, the agency must provide Medicaid to individuals who:

    1. Are age 19 or older and under age 65;
    2. Are not pregnant
    3. Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;
    4. Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and
    5. Have household income that is at or below 133 percent FPL for the applicable family size.

13. AHCT correctly determined the Appellant is enrolled in Medicare Part A and Part D.

14. AHCT correctly determined that Medicare Part A is minimum essential coverage.

15. AHCT correctly determined the Appellant ineligible for Husky D because the Appellant receives Medicare Part A.

16. AHCT correctly denied the Appellant's change reporting application for Medicaid /Husky D program because of his Medicare A eligibility.

## DECISION

The Appellant's appeal is **denied**.

Christopher Turner
Hearing Officer

Cc: Judith Boucher, Health Insurance Exchange, Access Health CT
Sabrina Solis, 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 Primary 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.

There is no right to request reconsideration for denials or reductions of Advanced Primary 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.