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

[redacted] **2017**
Signature Confirmation

Client # [redacted]
Hearing Request # 803634

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2016, the Health Insurance Exchange, Access Health CT ("AHCT") issued a Notice of Action ("NOA") to [redacted] (the "Appellant"), denying eligibility for Advance Premium Tax Credits ("APTC") for her household because she did not plan to file taxes.

On [redacted] 2016, the Appellant requested a hearing to contest AHCT's determination of ineligibility for APTC for her household.

On [redacted] 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, the Appellant requested a continuance of the hearing, which OLCRAH granted.

On [redacted] 2017, OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, the office was closed and OLCRAH rescheduled the hearing.

On [redacted] 2017, OLCRAH issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, the Appellant requested a continuance, which OLCRAH granted.

On [redacted] 2017, 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
Cathy Davis, AHCT Representative
Thomas Monahan, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT was correct when it determined that the Appellant was ineligible for the APTC.

FINDINGS OF FACT

1. On [redacted] 2016, the Appellant submitted an online Medicaid/Husky D change application form. (Exhibit 1: Application form)

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

3. The Appellant is 54 years old (DOB [redacted]/62). (Appellant's testimony, Ex. 1: Application form)

4. The Appellant receives Social Security Disability of $1,191.00 per month. (Appellant's testimony)

5. The Appellant receives Medicare Part A and B. (Ex. 5: Third Party Liability verification)

6. On [redacted] 2016, AHCT issued a notice to the Appellant. The notice stated the Appellant is not eligible for an APTC because she did not plan to file taxes. (Ex. 2: Denial Notice, [redacted]/16)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes 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. State statute 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. Conn. Gen. Stats. § 17b-264

3. 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.

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

5. 45 CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

6. Title 26 of the United States Code (“USC”) Section 5000A(f) provides for Minimum Essential Coverage. For purposes of this section –

(1) In general. The term “minimum essential coverage” means in part: A Government sponsored program including coverage under the Medicare program under Part A of the XVIII of the Social Security Act.

7. The Appellant has minimum essential coverage under the Medicare Part A.

8. 45 CFR §155.20 defines *Qualified health plan or QHP* as a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155.

9. 45 CFR §155.2 defines *Advance payments of the premium tax credit* as a payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the Affordable Care Act.

10. 45 CFR §155.305(f)(1) provides that in general, the Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that -

    (i) He or she is expected to have household income, as defined in 26 CFR 1.36B-1(e), of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and
    (ii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse -

        (A) Meets the requirements for eligibility for enrollment in a QHP through the Exchange as specified in paragraph (a) of the section; and
        (B) is not eligible for minimum essential coverage, with the exception of coverage in the individual market, in accordance with section 26 CFR 1.36B-2(a)(2) and (c).

11. 26 CFR §1.36B-2 Eligibility for premium tax credit. (a) In general. An applicable taxpayer (within the meaning of paragraph (b) of this section) is allowed a premium assistance amount only for any month that one or more members of the applicable taxpayer's family (the applicable taxpayer or the applicable taxpayer's spouse or dependent)-

    (1) Is enrolled in one or more qualified health plans through in Exchange; and

    (2) Is not eligible for minimum essential coverage (within the meaning of paragraph (c) of this section) other than coverage described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

12. 26 CFR §1.36B-2 Eligibility for premium tax credit.
    (c) Minimum essential coverage –
    (1) In general. Minimum essential coverage is defined in section 5000A(f) and regulations issued under that section. As described in section 5000A(f), government-sponsored programs, eligible employer-sponsored plans, grandfathered health plans, and certain other health benefits coverage are minimum essential coverage.

13. Since the Appellant is eligible for minimum essential coverage under the Medicare program, she does not qualify for a premium tax credit.

14. AHCT incorrectly denied the Appellant's application for APTC becuase she did not plan to file taxes.

15. Although AHCT did not state the proper reason for the denial, it has been determined through this hearing process that the Appellant is not eligible for the APTC because she has Medicare coverage.

DECISION

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

Thomas Monahan
Thomas Monahan
Hearing Officer

C: Judith Boucher, Health Insurance Exchange Access Health CT
Cathy Davis, 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.

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, 25 Sigourney Street, Hartford, CT 06106. 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.