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

Application # [redacted]
Hearing Request # 803814

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], denying eligibility for Advance Premium Tax Credits ("APTCs") for his household because of the availability of Affordable and Minimum Value coverage offered by his employer.

On [redacted] 2016, [redacted] (the "Appellant"), [redacted] spouse and the applicant head of household, requested a hearing to contest AHCT's determination of ineligibility for APTCs 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, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statues, OLCRAH held an administrative hearing.

The following individuals were present at the hearing:

[redacted] Appellant, via telephone
[redacted] Appellant's spouse, via telephone
Judith Boucher, Access Health CT Representative, via telephone
James Hinckley, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT was correct when it determined that the Appellant's household was ineligible for APTCs.

FINDINGS OF FACT

1. The Appellant's household includes five persons: herself, her Spouse, and their three minor children. (Hearing Record)

2. On [redacted] 2016, the Appellant applied to AHCT for an affordability program to help pay for health care coverage for the members of her household. (Ex. 1: [redacted] 2016 Application Information)

3. At the time of the Appellant's [redacted] 2016 application, The Appellant's spouse, [redacted] (her "Spouse"), was employed by [redacted] (his "Employer"). (Ex. 1).

4. On the [redacted] 2016 application form, the Appellant reported that her Spouse's annual earnings were $62,000.00. (Ex. 1)

5. On the [redacted] 2016 application form, the Appellant reported that the only source of income for her household was her Spouse's earnings. (Ex. 1)

6. On the [redacted] 2016 application form, the Appellant reported that her Spouse's Employer did not offer a health plan that meets the Minimum Value standard. (Ex. 1)

7. On [redacted] 2016, AHCT sent the Appellant a notice informing her that AHCT may contact any employer identified on her application to verify information including whether any individual in her household is eligible for qualifying coverage in an employer-sponsored plan. (Ex. 3: [redacted] 2016 notice re: Employee-Sponsored Minimum Essential Coverage Verification)

8. On [redacted] 2016, AHCT sent the Appellant's Spouse's Employer a notice informing the company that "large employers" that employ 50 or more full-time equivalent employees may be subject to a tax penalty pursuant to the Employer Shared Responsibility requirement of the Affordable Care Act (the "ACA") if they fail to offer their employees Affordable coverage that provides Minimum Value; the notice went on to define the parameters under which a health plan is considered to meet the "Affordability" and "Minimum Value" standards. (Ex. 4: [redacted] 2016 notice re: Notice of Employee Eligibility for Premium Assistance)

9. On [redacted] 2016, AHCT sent the Appellant a NOA advising her that, based on the circumstances she reported on her application, her Spouse was qualified to

receive up to $338.00 per month in premium tax credits for 2016 to apply toward paying for a health plan offered by AHCT. (Ex. 2: [redacted] 2016 Eligibility Decision for Healthcare Coverage Notice)

10. On [redacted] 2016, the Employer filed an appeal with AHCT to contest the Appellant's attestation that her Spouse's Employer did not offer Qualifying Coverage because, if the attestation were true, the company could be subject to an Employer Mandate tax penalty being imposed against it. (Ex. 5: Employer Mandate Appeal Form, Hearing Record)

11. On [redacted] 2016, AHCT sent a notice to the Appellant's Spouse explaining that his eligibility for APTCs was based on his representation that his Employer did not offer Affordable and Minimum Value coverage, and advising him that his Employer had filed an appeal challenging his eligibility to receive APTCs, and that if employer-sponsored qualifying coverage is available to him, he is not eligible for APTCs and may be required to repay some or all of the APTCs he has received. (Ex. 7: [redacted] 2016 Notice to Employee of AHCT's Receipt of an Employer Appeal)

12. The Appellant's Spouse's Employer employs more than 50 full-time equivalent employees. (Hearing Record, Ex. 5)

13. The Appellant's Spouse's Employer offers a health care plan through its insurance carrier, CIGNA, called the "Open Access Plus High Deductible Health Plan" ("OAP"), which CIGNA attests in its Summary of Benefits and Coverage for the plan, meets the ACA requirements for "minimum essential coverage" and "minimum value standard" for the benefits it provides. (Ex. 10: Employer Exhibit, Insurance Coverage Details, Ex. 12: Employer Exhibit, Summary of Benefits, Ex. 15: [redacted] Employee Benefits Summary)

14. The weekly cost to the Appellant's Spouse for the Employer-sponsored OAP health plan for coverage for the employee only, would be $43.22 per week, or $185.85 per month ($43.22 weekly x 4.3 weeks per month). (Ex. 14: Employee Benefit Plan Enrollment Form).

15. The Appellant's Spouse was offered coverage in the CIGNA OAP health plan for himself and his dependents by his Employer, but declined to enroll himself or any family member when he completed his Employer's enrollment form on [redacted] 2016. (Ex. 14)

16. As of [redacted] 2016, the Appellant's Spouse, after 30 cumulative weeks of employment in 2016, had year-to-date gross earnings of $38,640.00. (Ex. 8: Electrical Connection Inc. Earnings Detail).

17. The Spouse's 2016 gross monthly earnings, based on an average of his cumulative gross earnings so far during 2016, are $5,538.40 per month

($38,640.00, divided by 30 weeks = $1,288.00 per week, multiplied by 4.3 weeks per month). (Fact #16).

18. The cost to the Appellant's Spouse for employee-only OAP health coverage as a percentage of his gross wages would be 3.36 percent ($185.85 monthly premium, divided by $5,538.40 monthly gross pay, equals 3.36%. (Facts #14, #17).

19. On [redacted] 2016, AHCT notified the Appellant's Spouse of its determination that his employer did offer Minimum Value coverage to him and to his eligible dependents that was affordable based on the employee-only premium, and that, as a result, he is not eligible for APTCs. (Ex. 16: Notice to Employee of Decision on Employer Appeal).

20. The Appellant will continue to receive APTCs unless she updates her AHCT application with accurate information about employer-sponsored coverage so that her household's eligibility for APTCs can be redetermined; updating the record is the Appellant's responsibility, and if APTCs continue to be paid erroneously because of inaccurate information on file that she failed to correct, she/ her Spouse may be required to repay any/all APTCs when they file their taxes. (Ex. 16, AHCT Representative's testimony).

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. 26 CFR §54.4980H-2 provides in part that an applicable large employer is one that employs 50 or more full-time equivalent employees.

7. The Appellant's Spouse's employer is an applicable large employer under the provisions of 26 CFR §54.4980H-2.

8. 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).

9. The 2016 Poverty Guidelines (FPL) for the 48 Contiguous States and the District of Columbia are published in the Federal Register Vol. 81, No 15, [redacted] 2016, pp. 4036-4037. The 2016 Poverty Guideline for a household of 5 persons is $28,440 annually, and 400% of the Poverty Guideline for a household of 5 persons is $113,760 annually.

10. The Appellant's household's income of $5,538.40 monthly or $66,460.80 annually, is greater than 100 percent but not more than 400 percent of the FPL for 2016, thus the Appellant's Spouse is an applicable taxpayer with respect to eligibility for APTCs.

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 an 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)

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.

26 CFR §1.36B-2 **Eligibility for premium tax credit.**

(c) Minimum essential coverage –

(3) **Employer-sponsored minimum essential coverage –**

(i) **In general.** For purposes of section 36B, an employee who may enroll in an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and an individual who may enroll in the plan because of a relationship to the employee (a related individual) are eligible for minimum essential coverage under the plan for any month only if the plan is affordable and provides minimum value. Government-sponsored programs described in section 5000A(f)(1)(A) are not eligible employer-sponsored plans.

12. Title 26 of the United States Code ("USC") Section 5000A(f) **Minimum Essential Coverage** For purposes of this section –

(1) In general The term "minimum essential coverage" means any of the following:

(B) Employer-sponsored plan

Coverage under an eligible employer-sponsored plan.

13. 26 USC § 5000A(f)(2) **Eligible Employer-Sponsored Plan** The term "eligible employer-sponsored plan" means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is –

(A) a government plan (within the meaning of section 2791(d)(8) of the Public Health Service Act), or

(**B**) any other plan or coverage offered in the small or large group market within a State.

Such term shall include a grandfathered health plan

14. 26 USC § 36B(c)(2)(C) **Special rule for employer-sponsored minimum essential coverage** For purposes of subparagraph (B)--

(i) Coverage must be affordable Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2), and

(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceed 9.5 percent of the applicable taxpayers household income.

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

(ii) coverage must provide minimum value. Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

(iii) Employee or family must not be covered under employer plan. Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

(iv) Indexing

In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

15. The OAP employer-sponsored healthcare plan offered by the Appellant's Spouse's Employer was coverage which qualified under ACA requirements as both providing minimum essential coverage and meeting the minimum value standard for the benefits the plan provided; CIGNA, the insurance carrier, attested to those facts in the Summary of Benefits and Coverage for the plan.

16. In order to be considered qualifying coverage with respect to eligibility for APTCs, the employer-sponsored coverage must, in addition to meeting the minimum essential coverage and minimum value standard, meet the affordability test specified in the Special Rule for employer-sponsored minimum essential coverage in 26 USC § 36B(c)(2)(C).

17. 26 USC § 36B(c)(2)(C)(i)(II) provides that employer-sponsored coverage is not affordable if the employee required contribution with respect to the plan exceeds 9.5 percent of the applicable taxpayer's income; clause (iv) provides for indexing of the 9.5 percent under clause (i)(II) for any calendar year after 2014. Internal Revenue Bulletin 2014-50 Rev. Proc. 2014-62 Section 2.02 provides: *Section 36B Required Contribution Percentage for 2016*. For plan years beginning in 2016, the required contribution percentage for purposes of § 36B(c)(2)(C)(i)(II) is 9.66%.

18. The Appellant's Spouse's required premium contribution for the OAP plan offered by his Employer for self-only coverage, as a percentage of his gross income, is 3.36%, which is less than the 9.66% standard in 26 USC § 36B(c)(2)(C)(i)(II), thus the coverage is considered affordable.

19. The OAP health plan offered by the Appellant's Spouse's Employer qualifies as employer-sponsored minimum essential coverage; it meets the minimum essential coverage and minimum value standards, and meets the test of being affordable to the specific individual applicable taxpayer (the Appellant's Spouse).

20. The Appellant's Spouse cannot be eligible for APTCs unless one or more members of his family is not eligible for minimum essential coverage; because qualifying employer-sponsored minimum essential coverage was available to the Appellant's Spouse and to all of the members of his family, he was not eligible for APTCs.

21. AHCT was correct when it determined that the Appellant's household was not eligible for APTCs.

DECISION

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

James Hinckley
Hearing Officer

cc: Judith Boucher, Health Insurance Exchange Access Health CT
Rita Baboolal, 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.