

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

██████████ 2017  
Signature Confirmation

CLIENT No # ██████████  
Request # 814407

NOTICE OF DECISION

PARTY

██████████  
██████████  
██████████

PROCEDURAL BACKGROUND

On ██████████ 2017, the Health Insurance Exchange Access Health CT- (“AHCT”) denied ██████████ ██████████ (“Appellant”) application for Medicaid Husky D healthcare coverage.

On ██████████ 2017, the Appellant requested an administrative hearing to contest the decision to deny Medicaid/ Husky D benefits.

On ██████████ 2017, the Office of Legal Counsel, Regulations, and Administrative Hearings (“OLCRAH”) issued a notice scheduling the administrative hearing for ██████████ ██████████ 2017.

On ██████████ 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 were present at the hearing:

██████████ Appellant  
Debra Henry, AHCT Representative  
Scott Zuckerman, Hearing Officer

### **STATEMENT OF THE ISSUE**

The issue to be decided is whether ACHT correctly denied the Medicaid/Husky D benefits.

### **FINDINGS OF FACT**

1. On [REDACTED] 2017 the Appellant turned sixty-five (65) years old (DOB: [REDACTED]/52). (Appellant's Testimony, Exhibit 1: Application form)
2. On [REDACTED] [REDACTED] 2017, AHCT discontinued the Appellant's Medicaid/Husky D because he turned 65 and began receiving Medicare benefits. (Appellant's testimony, Access Health Testimony)
3. On [REDACTED] 2017, the Appellant contacted AHCT to inquire about his benefits and AHCT completed an online Medicaid/ Husky D change reporting application form on behalf of the Appellant. The Appellant reported he was receiving Medicare medical benefits. (Exhibit 1: Application form)
4. The Appellant is not requesting Medicaid coverage for himself. (Ex. 1)
5. The Appellant's household consists of one person. (Ex.1: Application form)
6. Effective [REDACTED] 2017, the Appellant began receiving Medicare coverage. (Appellant's testimony, Ex. 1)
7. On [REDACTED] 2017, AHCT issued the Appellant a notice. The notice stated the Appellant did not request health coverage for himself. (Ex. 3: We Updated Your Health Care Application, [REDACTED]/17)

### **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. Section § 17b-264 of the Connecticut General Statutes 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. 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) or 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. 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.
7. 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.
8. 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).
9. 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.

10. 42 CFR § 435.119(b) provides that effective January 1, 2014, the agency must provide Medicaid to individuals who:
- a. Are age 19 or older and under age 65;
  - b. Are not pregnant
  - c. Are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act;
  - d. 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
  - e. Have household income that is at or below 133 percent FPL for the applicable family size.
11. AHCT correctly determined the Appellant was enrolled in Medicare coverage.
12. AHCT correctly determined that Medicare coverage is minimum essential coverage.
13. AHCT correctly determined the Appellant is not eligible for Medicaid/ Husky D benefits because he is receiving minimum essential coverage and he did not request Medicaid coverage.

**DECISION**

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

  
Scott Zuckerman  
Hearing Officer

CC: Judith Boucher, Health Insurance Exchange, Access Health CT  
Debra Henry, Health Insurance Exchange, Access Health CT

**Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (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 APTC or CSR.

**Modified Adjusted Gross Income (MAGI) Medicaid and**  
**Children's Health Insurance Program (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 APTC or 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.