STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06105-3730

[redacted] **2017**
Signature Confirmation

Client ID # [redacted]
Application ID # [redacted]
Hearing Request # 820524

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, Health Insurance Exchange Access Health CT ("AHCT") issued a notice to [redacted] (the "Appellant") denying eligibility for a Qualified Health Plan ("QHP") with an Advanced Premium Tax Credit ("APTC") because the Appellant did not apply within the open enrollment period.

On [redacted] 2017, the Appellant requested an administrative hearing to contest AHCT's decision to deny eligibility for a QHP with an APTC.

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, 17-61 and 4-176e to 4-189 inclusive, of the Connecticut General Statutes, Title 45 of the 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 participated in the hearing:

[redacted] Appellant
Rita Baboolal, Access Health CT Representative
Thomas Monahan, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly denied the Appellant's QHP with APTC.

FINDINGS OF FACT

1. On [redacted] 2016, AHCT discontinued the Appellant's Husky D and approved her for a QHP with an APTC. (Hearing record)

2. The Appellant did not pick a QHP within 60 days. (Hearing record)

3. The Appellant does not recall receiving a letter regarding the discontinuance of her Husky D and approval for APTC's through her QHP. (Appellant's testimony)

4. On [redacted] 2017, the Appellant contacted AHCT to inquire on her eligibility after she was refused a prescription because she did not have healthcare coverage. (Appellant's testimony)

5. On [redacted] 2017, the Appellant applied for health insurance coverage through AHCT. (Exhibit 1: Application form)

6. In [redacted] of 2017, the Appellant ended employment as a day care provider and began employment as a school para professional earning $830.00 bi-weekly. (Appellant's testimony)

7. The Appellant did not have employer insurance at either job. . (Appellant's testimony)

8. The Appellant is single and has no dependents. (Appellant's testimony)

9. The Appellant is 26 years old (DOB [redacted]/1990). (Appellant's testimony)

10. The Open Enrollment period began November 1, 2016 and ended January 31, 2017. (AHCT testimony)

11. On [redacted] 2017, AHCT determined the Appellant was not eligible for a QHP with APTC because she failed to apply within the open enrollment period and the she did not have a qualifying event to qualify for special enrollment. (Hearing Summary, Ex. 2: Application results, [redacted]/17, Ex. 3: Eligibility Determination Results)

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 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. [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) 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 155.410 (a) (1) (2) General requirements. Provides the Exchange must provide an initial open enrollment period and annual open enrollment periods consistent with this section, during which qualified individuals may enroll in a QHP and enrollees may change QHPs. The Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the

initial open enrollment period specified in paragraph (b) of this section, the annual open enrolment period specified in paragraph (e) of this section, or a special enrollment period described in §155.420 of this subpart for which the qualified individual has been determined eligible.

7. 45 CFR 155.410 (d) Notice of annual open enrollment period. Starting in 2014, the Exchange must provide a written annual open enrollment notification to each enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first of the open enrollment period.

8. 45 CFR 155.410 (e) (2) pertains to the Annual open enrollment period. For the benefit years beginning on January 1, 2016, on January 1, 2017, and on January 1, 2018, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

9. The Appellant did not enroll in a healthcare coverage plan between November 1, 2016 and January 31, 2017.

10. 45 CFR 155.420 (c) Availability and length of special enrollment periods provides (1) General rule. Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

11. 45 CFR 155.420 (d) The 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 occurs.

    (1) The qualified individual or his or her dependents either: (i) lose 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 health insurance policy that will expire in 2014 as described in § 147.104 (b). (iii) Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Act (42 U.S.C. 396a(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.

(3) The qualified individual, or his or her dependent, which was not previously a citizen, national, or lawfully present individual gains such status;

(4) The qualified individual's or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct includes the failure to comply with applicable standards under this part, part 156 of this subchapter, or other applicable Federal or State laws as determined by the Exchange.

(5) The enrollee or, his or her dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) *Newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.* (i) The enrollee is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;(ii) The enrollee's dependent enrolled in the same QHP is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions; or(iii) A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B- 2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.(iv) A qualified individual in a non-Medicaid expansion State who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL, who was ineligible for Medicaid during that same timeframe, and who has experienced a change in household income that makes the qualified individual newly eligible for advance payments of the premium tax credit.

(7) The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move; an either (i) Had minimum essential coverage as described in 26 CFR 1.5000A-1(b) for one or more days during the 60 days preceding the date of the permanent move, or (ii) Was living outside of the United States or in a United States territory at the time of the permanent move;

(8) The qualified individual-Who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; or (ii) Who is or

becomes a dependent of an Indian, as defined by section 4 of the Indian Health Care Improvement Act and is enrolled or is enrolling in a QHP through an Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

(9) The qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

(10) A qualified individual or enrollee—

(i) Is a victim of domestic abuse or spousal abandonment, as defined by 26 CFR 1.36B-2T, as amended, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or
(ii) Is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim.

(11) A qualified individual or dependent—

(i) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or

(ii) Applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;

(12) The qualified individual or enrollee, or his or her dependent, adequately demonstrates to the Exchange that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a QHP through the Exchange; or

(13) At the option of the Exchange, the qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in §155.315 or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence.

12. The Appellant did not meet the criteria needed to qualify for a special enrollment period.

13. AHCT correctly denied the qualified health plan with APTC because the Appellant did not apply during the open enrollment period from November 1, 2016 through January 31, 2017 and did not select a QHP within 60 days of her initial QHP grant of [redacted] 2017.

DECISION

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

Thomas Monahan
Thomas Monahan
Fair Hearings Officer

C: Judy Boucher, Health Insurance Exchange Access CT
Rita Baboolal, Health Insurance Exchange Access 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 of APTC or CSR.