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 ID # [redacted]
Client ID # [redacted]
Hearing Request # 823401

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, Health Insurance Exchange Access Health CT ("AHCT") issued a Notice of Action ("NOA") to [redacted] (the "Appellant"), denying the Appellant's daughter Medicaid/HUSKY D healthcare coverage.

On [redacted] 2017, the Appellant requested an administrative hearing to contest the denial of Medicaid/HUSKY D healthcare coverage for his daughter.

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, chapter 45 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, AHCT Representative
Maureen Foley-Roy, Hearing Officer

The hearing officer held the record open for the submission of additional evidence. On [redacted] 2017, the record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly denied the Medicaid/HUSKY D healthcare coverage for the Appellant's daughter.

FINDINGS OF FACT

1. On [redacted] 2016, AHCT sent the Appellant a notice advising that they would be renewing eligibility for HUSKY health care coverage for the Appellant's daughter, [redacted] (Appellant's Exhibit B: Health Care Coverage Renewal Decision Notice)
2. On [redacted] 2016, AHCT sent the Appellant a notice requesting proof of citizenship for her daughter [redacted] or [redacted] medical benefits would terminate [redacted] 2017. The Appellant provided AHCT with the requested information. (Appellant's Exhibit D: additional verification required notice and Appellant's testimony)
3. On [redacted] 2016, the Appellant spoke with AHCT brokers regarding her own medical insurance plan. She stated that her husband did not want coverage and that her daughter was covered through HUSKY. (Exhibit 6: Email from AHCT with case notes)
4. On [redacted] 2016, AHCT mailed the Appellant a notice advising the Appellant that she qualified to buy health insurance and for premium tax credits and cost sharing benefits for both 2016 and 2017. It also stated that she had not chosen a health insurance plan for 2017 and that her daughter [redacted] qualified for both HUSKY B and to purchase health insurance for 2017. (Appellant's Exhibit E: Notice #1 sent [redacted] 2016)
5. On [redacted] 2016, AHCT mailed the Appellant a notice advising that she qualified to buy health insurance and for premium tax credits and cost sharing benefits for 2016 and 2017. It also stated that she had not chosen a health insurance plan for 2017. The notice indicated that the Appellant's daughter's HUSKY coverage would end effective [redacted] 2017 but did not state a reason for the termination. The notice provided premium information regarding the daughter's HUSKY B coverage. (Exhibit F: Notice #2 sent [redacted] 2016)
6. On [redacted] 2016, AHCT mailed the Appellant a notice advising that qualified to buy health insurance and for premium tax credits and cost sharing benefits for 2016 and 2017. It also stated that she had not chosen a health insurance plan for 2017. The notice indicated that the Appellant's daughter's HUSKY coverage would end effective [redacted] 2017 but did not state a reason for the termination. The notice did provide premium information regarding the daughter's HUSKY B coverage. (Exhibit F: Notice #3 sent [redacted] 2016)
7. On [redacted] 2016, AHCT mailed the Appellant a notice advising that she was qualified to buy health insurance and for premium tax credits and cost sharing benefits for 2017. It also stated that she had chosen a health insurance plan and that the Appellant's daughter and husband had not

requested coverage. (Exhibit 5: Results of Health Care Renewal mailed [redacted] 2016)

8. AHCT disenrolled the Appellant's daughter from HUSKY coverage effective [redacted] 2016. (Exhibit 3: Enrollment details)

9. On [redacted] 2017, the Appellant's daughter turned 19 years old. (Exhibit 1: Application).

10. Sometime in the spring of 2017, the Appellant's daughter went to obtain a prescription and learned that she had no health insurance. (Appellant's testimony)

11. On [redacted] 2017, AHCT sent the Appellant a notice advising that her daughter was ineligible for HUSKY D and did not have a reason to enroll in 2017 health insurance outside of the open enrollment period. (Exhibit I: Notice of [redacted] 2017)

12. On [redacted] 2017, the Appellant applied for medical insurance through AHCT. (Exhibit 1)

13. On [redacted] 2017, AHCT mailed a notice advising the Appellant that no one in her household qualified for HUSKY D/Medicaid because the household's income exceeded the allowable limit. The notice also stated that the Appellant and her daughter were qualified to purchase a health insurance plan and for premium tax credits and cost sharing reductions. The notice stated both that the Appellant had already chosen a medical insurance plan and that she and her daughter needed to pick a plan. (Exhibit 4: Notice mailed [redacted] 2017)

14. AHCT advised the Appellant that her daughter does not qualify to purchase a medical insurance plan because she did not apply during the open enrollment period of [redacted] 2016 and [redacted] 2017. She does not have a qualifying event which would allow AHCT to enroll her during a special enrollment period. (Hearing Summary and 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 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 § 155.505(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. 42 CFR § 431.210 provides for content of notice. A notice required under §431.206 (c)(2), (c)(3), or (c)(4) of this subpart must contain—(a) A statement of what action the agency, skilled nursing facility, or nursing facility intends to take and the effective date of such action;(b) A clear statement of the specific reasons supporting the intended action;(c) The specific regulations that support, or the change in Federal or State law that requires, the action;(d) An explanation of—(1) The individual's right to request a local evidentiary hearing if one is available, or a State agency hearing; or(2) In cases of an action based on a change in law, the circumstances under which a hearing will be granted; and (e) An explanation of the circumstances under which Medicaid is continued if a hearing is requested.

7. 42 CFR § 435.917(a)(1) provides for *Notice of eligibility determinations.* Consistent with §§431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services. Such notice must— (1) Be written in plain language.

8. 42 CFR § 435.917 (b)(2) provides for *content of notice*:(2) Notice of adverse action including denial, termination or suspension of eligibility or change in benefits or services. Any notice of denial, termination or suspension of Medicaid eligibility or change in benefits or services must be consistent with §431.210 of this chapter.

9. 42 CFR § 435.917 (c)(1) & (2) provides for *Eligibility.* Whenever an approval, denial, or termination of eligibility is based on an applicant's or beneficiary's having household income at or below the applicable modified adjusted gross income standard in accordance with §435.911, the

eligibility notice must contain—(1) Information regarding bases of eligibility other than the applicable modified adjusted gross income standard and the benefits and services afforded to individuals eligible on such other bases, sufficient to enable the individual to make an informed choice as to whether to request a determination on such other bases; and (2) Information on how to request a determination on such other bases

10. AHCT did not send the Appellant proper notice regarding the actions taken on her case with regards to her daughter's eligibility for Medicaid.

11. 42 CFR § 435.118(b)(2)(ii) provides that the agency must provide Medicaid to children under age 19 whose income is at or below the income standard established by the agency in its State Plan.

12. AHCT was incorrect when it discontinued the Appellant's daughter's HUSKY B medical coverage effective [redacted] 2016.

13. AHCT was incorrect in [redacted] of 2017 when it did not allow the Appellant to purchase a qualifying health plan for her daughter.

DISCUSSION

The Appellant had telephone contact with AHCT brokers in November regarding the insurance plan that she was choosing for her own coverage. Notices from AHCT indicate that HUSKY medical assistance for the Appellant's daughter, [redacted] had been renewed. During her conversation with the brokers, the Appellant stated that her husband did not need coverage and that her daughter was covered through HUSKY. On [redacted] 2017, AHCT mailed the Appellant four notices appearing to stem from the phone conversation advising the Appellant of the plan that she had chosen. Two of the notices indicated on a chart that the HUSKY B medical coverage for the Appellant's daughter would terminate effective [redacted] 2016. One of the notices stated that the daughter did not request coverage. There was no reason given for any termination of the daughter's HUSKY coverage. The daughter subsequently learned that she had no insurance coverage and the family reapplied through AHCT. ([redacted] had turned 19 in [redacted] and HUSKY B was no longer an option due to her age.) AHCT determined that the family was ineligible for HUSKY D but stated that the Appellant and her daughter could purchase a plan and were eligible for premium tax credits and cost sharing reductions. At the hearing the representative testified that the daughter could not purchase a plan because it was outside the open enrollment period and that she had not had a qualifying event which would allow AHCT to create a special enrollment period for her.

There seems to be no recognition on the part of AHCT that their erroneous termination of [redacted] HUSKY medical coverage in [redacted] of 2016 triggered the events leading to [redacted] lack of medical coverage. If the case had been handled correctly, the HUSKY coverage would have continued until [redacted] turned 19 in [redacted] At that point AHCT would have had to review eligibility for [redacted] Subsequent actions indicate that as an adult, [redacted] is ineligible for HUSKY but would have been eligible to purchase insurance and for cost sharing benefits in [redacted] of 2017 when she contacted AHCT about the

termination of her coverage.

DECISION

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

ORDER

AHCT is ordered to reinstate HUSKY B coverage for the Appellant's daughter for the period from [redacted] 2016 through [redacted] 2017. Effective [redacted] 2017, the Appellant's daughter is qualified to buy health insurance for the remainder of 2017 and for premium tax credits and cost sharing benefits.

Compliance with this order is due by [redacted] 2017.

Maureen Foley-Roy

Maureen Foley-Roy
Hearing Officer

Pc: Rita Baboolal, Health Insurance Exchange Access Health CT

Judy Boucher, 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 06105-3725.

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, 55 Farmington Avenue, Hartford, CT 06105-3725. 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.