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

[redacted] **2017**
Signature Confirmation

Application # [redacted]
Hearing Request # 826701

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Health Insurance Exchange Access Health CT ("AHCT") sent [redacted], (the "Appellant") a notice discontinuing the Qualified Health Plan ("QHP") for his household effective [redacted] 2017 for failure to provide verification.

On [redacted] 2017, The Appellant requested a hearing to contest the discontinuance of the health care coverage.

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, 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:

[redacted] Appellant's spouse and Representative
Tamiste King, Access Health CT Representative
Veronica King, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Access Health CT correctly discontinued the household's health care coverage.

FINDINGS OF FACT

1. On [redacted] 2016 The Appellant applied for health care coverage through Access Health CT ("AHCT") for himself, his spouse and two minor children. (Exhibit 1: Application ID [redacted] notices and Hearing Record)

2. On [redacted] 2016, AHCT sent a notice to the Appellant requesting proof of citizenship and identity for all household members no later than [redacted]/17. (Exhibit 1)

3. AHCT sent "Reminder-Additional Documents Needed" notices to the Appellant on [redacted]/17, [redacted]/17 and, [redacted]/17 the notices reminded the Appellant of the additional verification required on [redacted]/16. The notice also says that the documents had to be submitted by [redacted]/17. (Exhibit 1)

4. Between December [redacted]/16 and [redacted]/16, the Appellant initiated five applications for health care coverage through AHCT. (Exhibit 1, Exhibit 2: Application ID [redacted] notices, Exhibit 3: Application ID [redacted] notices, Exhibit 4: Application ID [redacted] notices, Exhibit 5: Application ID [redacted] notices and Hearing Record)

5. AHCT requested proof of Citizenship and Identity for the household members. (Exhibit 1, Exhibit 2, Exhibit 3, Exhibit 4 and, Exhibit 5)

6. On [redacted] 2017, AHCT sent a notice to the Appellant informing him that his health care coverage was ending. The notice stated that because he did not provide the requested documents, his household's health overage last day will be [redacted] 2017. (Exhibit 8: Health Coverage Ending notice, [redacted]/17)

7. On [redacted] 2017, AHCT received verification of citizenship and identity for all members of the household. (Hearing Record)

8. AHCT did not review the documents because they were not received within requested due date. (Hearing Record)

9. The Appellant received all notices requesting the additional verifications. (Appellant's testimony)

10. The Appellant did not provide any of the requested documents before [redacted] 2017. (Appellant'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. 45 CFR § 155.320 (B) provides for the verification process related to eligibility for insurance affordability programs; If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed in accordance with section 6103(l)(21) of the Code and its accompanying regulations, the Exchange must proceed in accordance with §155.315(f)(1).

7. 45 CFR § 155.315(f)(1)(2) provides for the verification process related to eligibility for enrollment in a QHP through the Exchange, except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify

information required to determine eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions, including when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination are not included in such data sources or when electronic data from IRS, DHS, or SSA is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, the Exchange:

(1) Must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;
(2) If unable to resolve the inconsistency through the process described in paragraph (f)(1) of this section, must—
    (i) Provide notice to the applicant regarding the inconsistency; and
    (ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in §155.405(c), except for by telephone through a call center, or otherwise resolve the inconsistency.

8. 45 CFR § 155.310 (K) (1)(2)(3)pertains to an incomplete application. If an application filer submits an application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for insurance affordability programs, if applicable, the Exchange must –
   (1) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; and
   (2) provide the applicant with a period of no less than 10 days and no more than 90 days from the date on which the notice described in paragraph (k)(1) of this section is sent to the applicant to provide the information needed to complete the application to the Exchange. And
   (3) During the period described in paragraph (k)(2) of this section, the Exchange must not proceed with an applicant's eligibility determination or provide advance payments of the premium tax credit or cost sharing reductions, unless an application filer has provided sufficient information to determine his or her eligibility for enrollment in a QHP through the Exchange , in which case the Exchange must make such a determination for enrollment in a QHP.

9. AHCT correctly issued notices to the Appellant that requested additional documents needed to validate eligibility for healthcare coverage.

10. AHCT correctly provided the Appellant with a period of no less than 10 days and no more than 90 days from the application date, to provide the information to determined eligibility for QHP.

11. AHCT correctly determined that the Appellant did not provide information within 90 days from the application date.

12. AHCT correctly discontinued the Appellant's family's QHP when it determined that it did not have sufficient verification to validate eligibility for healthcare coverage.

DECISION

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

Veronica King

Veronica King
Hearing Officer

Pc: Judy Boucher, 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 of APTC or CSR.