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

[redacted] **2019**
Signature Confirmation

Case ID # [redacted]
Client ID # [redacted]**0**
Hearing ID #131265

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Health Insurance Exchange Access Health CT ("AHCT") issued a Notice of Action ("NOA") to [redacted], (the "Appellant") denying eligibility for Advanced Premium Tax Credits ("APTC").

On [redacted] 2018, the Appellant requested a hearing to contest the denial of the APTC.

On [redacted], 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted], 2018.

On [redacted], 2018, the Appellant requested to reschedule her administrative hearing.

On [redacted] 2018, the OLCRAH reissued a notice rescheduling administrative hearing for [redacted], 2018.

The Appellant did not appear for her administrative hearing scheduled for [redacted] 2018.

On [redacted] 2019, the Appellant requested another reschedule as she is trying to resolve the issue with AHCT.

On [redacted] 2019, the OLCRAH issued another notice rescheduling administrative hearing for [redacted], 2019 at the Appellant's request.

On [redacted], 2019, the Appellant requested another reschedule as she is trying to get the issue resolved.

On [redacted], 2019, the OLCRAH issued another notice rescheduling administrative hearing for [redacted] 2019.

On [redacted] 2019, in accordance with sections 17b-60, 17b-264 and 4-176e to 4-189, inclusive, of the Connecticut General Statues, chapter 45 Code of Federal Regulations ('CFR") §§ 155.505(b) and/or 42 CFR § 457.1130. OLCRAH held an administrative hearing. The following individuals participated in the hearing:

[redacted], Appellant
Krystal Sherman-Davis, Access Health CT Representative
Swati Sehgal, Hearing Officer

The hearing record remained open for the submission of additional evidence. On [redacted] 2019, the hearing record closed.

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly denied eligibility for Advanced Premium Tax Credits ("APTC").

FINDINGS OF FACT

1. The Appellant is the only person in her household. (Exhibit 3: Application Print out)
2. The Appellant is [redacted] years old (DOB [redacted]). (Exhibit 3)
3. In [redacted] 2018, the Appellant was receiving Qualified Health Plan ("QHP") with APTC. (Appellant's Testimony)
4. In [redacted] 2018, the Appellant was granted Medicare part A and B with an effective date of [redacted] 2018. (Appellant's Testimony)

5. The Appellant contacted the Social Security Office to terminate her Medicare. She was informed about penalties and was advised to contact AHCT to confirm that she would keep on getting her QHP with APTC after she terminates her Medicare benefits by a Social Security representative. (Appellant's Testimony)

6. The Appellant contacted AHCT and was informed by an AHCT representative that she can keep her QHP with APTC if she terminates her Medicare benefits. Subsequently the Appellant called the Social Security office and terminated her Medicare B part. The Appellant was informed by Social Security Administration that she cannot disenroll from Medicare part A. (Appellant's Testimony)

7. On [redacted] 2018, the Appellant received a Notice from AHCT informing her that she does not qualify for APTC as she is enrolled in Medicare. It further stated that her monthly premium for her selected Health insurance plan is $996.45. (Exhibit 1: Notice 1301; [redacted])

8. The Appellant has been working with Department of Aging, Social Security Administration and AHCT's Insurance Resolution Department to resolve this issue for months. (Appellant's Testimony)

9. The AHCT's Insurance Resolution Department was able to confirm the Appellant was provided with wrong information to terminate her Medicare benefits in order to keep her eligibility for QHP with APTC. (Appellant's Testimony, AHCT representative's testimony)

10. The Appellant was further informed by AHCT's Insurance Resolution Department that her QHP would be denied retroactively from [redacted] 2018 through [redacted] 2018. (Appellant's Testimony)

11. On [redacted], 2019, the Appellant received a letter from Social Security Administration stating her Medicare part B was retroactively granted effective [redacted] 2018. (Appellant's Testimony)

12. On [redacted], 2019, the Appellant sent an email to AHCT's Insurance Resolution Department informing them of her Medicare Part B reinstatement effective [redacted] 2018. (Appellant's Testimony)

13. "The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2018. Therefore, this decision is due not later than [redacted] 2019. However, the hearing, which was originally scheduled for [redacted], 2018, was rescheduled for [redacted], 2018, at the Appellant's request, which caused an 18 day delay. The Hearing which was scheduled for [redacted] 2018, was again rescheduled for [redacted], 2019, at the Appellant's request, which caused a 70 day delay. Hearing which was scheduled for [redacted],

2019, was again rescheduled for [redacted], 2019, at the Appellant's request, which caused another 25 day delay. Because this 113 day (18+70+25) delay resulted from the Appellant's request, this decision is not due until [redacted], 2019, and is therefore timely.

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("Conn. Gen. Stat.") 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 Conn. Gen. Stat. 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 ("C.F.R.") § 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 C.F.R. § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

5. 45 C.F.R. §155.20 states Exchange means a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a SHOP serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.

6. 45 C.F.R. § 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.

7. 26 C.F.R. § 1.36B-2(a) provides that an applicable taxpayer 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).

8. 45 C.F.R. § 156.600 provides the term minimum essential coverage has the same meaning as provided in section 5000A(f) of the Code and its implementing regulations for purposes of this subpart.

9. Title 26 of the United States Code ("USC") Section 5000A)(f)(1)(A) provides that the Medicare program under part A of title XVIII of the Social Security Act is minimum essential coverage.

10. 42 C.F.R. §600.305(a)(3) provides that individuals are eligible to enroll in a standard health plan if they are not eligible to enroll in a minimum essential coverage (other than a standard health plan). If an individual meets all other eligibility standards, and

    (i) Is eligible for, or enrolled in, coverage that does not meet the definition of minimum essential coverage, including Medicaid that is not minimum essential coverage, the individual is eligible to enroll in a standard health plan without regard to eligibility or enrollment in Medicaid, or
    (ii) is eligible for Employer Sponsored Insurance ("ESI") that is unaffordable (as determined under section 36B(c)(2)(C) of the Internal Revenue Code), the individual is eligible to enroll in a standard health plan.

11. The Appellant is eligible for and enrolled in Medicare Part A and Part B healthcare coverage.

12. Medicare Part A meets the definition of minimum essential coverage.

13. AHCT incorrectly informed the Appellant that her eligibility will remain for QHP with APTC if she terminates her Medicare benefits.

14. AHCT has acknowledged the error and working with the Appellant to close her QHP effective [redacted] 2018.

15. AHCT correctly denied APTC because the Appellant had minimum essential coverage.

DISCUSSION

The Appellant was provided with incorrect information from the AHCT's Representative, which caused the Appellant to disenroll herself from Medicare Part B. Consequently the Appellant had to wait several months for Social Security Administration to reinstate her Medicare Part B benefits. AHCT's representative stated that their Insurance Resolution Department is working to resolve the issue.

DECISION

The Appellant's appeal is **DENIED** because the Appellant had minimum essential coverage through Medicare and did not qualify to receive APTC.

Swati Sehgal

Swati Sehgal
Hearing Officer

Pc: Sabrina Solis, Health Insurance Exchange Access Health CT
Amanda Maloney, 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.