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]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Health Insurance Exchange Access Health CT ("AHCT") issued a notice of action 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] 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted] 2019.

On [redacted] 2019, in accordance with sections 17b-60, 17b-61 and 4-176e to 4-184, inclusive, of the Connecticut General Statues, Title 45 Code of Federal Regulations ('CFR") § 155.505(b) and/or 42 of the CFR § 457.1130, OLCRAH held an administrative hearing by telephone.

The following individuals participated in the hearing:

[redacted] Appellant's Spouse
Krystal Sherman-Davis, Access Health CT Representative
Christopher Turner, Hearing Officer

The Appellant did not participate in the hearing.

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly denied the Appellant's application for an APTC.

FINDINGS OF FACT

1. On [redacted] 2018, AHCT completed a change reporting application in order to renew the Appellant's healthcare coverage for 2019. (Exhibit 5: Application dated [redacted]18, Hearing summary)

2. On [redacted] 2018, AHCT determined the Appellant eligible to buy health insurance for 2019. The Appellant's monthly premium for [redacted] was determined to be $[redacted] without an APTC due to Medicare Part A coverage. (Exhibit 3: Notice dated [redacted]18; Hearing summary)

3. The Appellant resides with his spouse [redacted]. (Exhibit 5: Application summary; Spouse's testimony)

4. The Appellant is [redacted]. (Exhibit 5)

5. The Appellant has been a recipient of Medicare Part A since [redacted] 2017.

6. The Appellant is currently receiving Medicare Part A benefits. (Record; Spouse's testimony)

7. The Appellant's Medicare Part B coverage will take effect [redacted] 2019. (Record; Spouse's testimony

8. Medicare Part A does not cover doctor visits or prescriptions. (Appellant's testimony)

CONCLUSIONS OF LAW

1. Connecticut General Statutes Section (§) 17b-2 provides that the Department of Social Services is designated as the state agency for the administration of (6) the Medicaid program pursuant to Title XIX of the Social Security Act.

2. Connecticut General Statutes § 17b-260 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.

3. Connecticut General Statutes § 17b-264 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.

4. Title 45 of the 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: (2) The State Medicaid agency, or any other State agency that meets the qualification of paragraph (a)(1) of this section.

5. Title 45 of the CFR § 155.505(c) provides that Exchange eligibility appeals may be conducted by a (1) 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.

6. Title 45 of the CFR § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

7. Title 45 of the CFR § 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.

8. Title 26 of the CFR § 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).

9. Title 26 of the United States Code Section 5000(A) (f) provides for purposes of this section (1) In general, the term "minimum essential coverage means any of the following: (A) Government sponsored programs (i) the Medicare program under part A of title XVIII of the Social Security Act is minimum essential coverage.

10. Title 42 CFR §600.305 provides for eligible individuals. (a) The State must determine individuals eligible to enroll in a standard health plan if they: (3) 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, 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.

The Appellant is enrolled in Medicare Part A.

Medicare Part A meets the definition of minimum essential coverage.

AHCT correctly determined the Appellant did not qualify for APTC because he is eligible for minimum essential coverage.

DECISION

The Appellant's appeal is denied.

Christopher Turner
Hearing Officer

Cc: Becky Brown, Health Insurance Exchange Access Health CT
Mike Towers, Health Insurance Exchange Access Health CT
Krystal Sherman-Davis, 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.