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

[redacted] **2021**
Signature Confirmation

[redacted]
Hearing # 179737

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2021, the Health Insurance Exchange Access Health CT ("AHCT") issued a Notice of Action ("NOA") to [redacted] (the "Appellant"), discontinuing his HUSKY D Medicaid ("HUSKY D") healthcare coverage.

On [redacted] 2021, the Appellant requested an administrative hearing to contest the discontinuance of the HUSKY D.

On [redacted] 2021, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2021.

On [redacted] 2021, 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 ("C.F.R.") §§ 155.505(b) and 155.510 and/or 42 C.F.R. § 457.1130, OLCRAH held an administrative hearing by telephone. The following individuals participated in the telephone hearing:

[redacted], Appellant
Sabrina Solis, AHCT Representative
Carla Hardy, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Health Insurance Exchange Access Health CT ("AHCT") correctly discontinued the HUSKY D healthcare coverage.

FINDINGS OF FACT

1. Prior to [redacted] 021, the Appellant was active on HUSKY D healthcare coverage. (Hearing Record)

2. The Appellant is the only person in his household. (Exhibit 4: Application, [redacted] 21; Hearing Summary)

3. The Appellant is 65 years old (DOB [redacted]/56). (Exhibit 4: Application)

4. The Appellant is a recipient of Medicare, part A and part B. (Appellant's Testimony)

5. The Appellant was informed by the Department of Social Services that he has a Medicare Savings Plan. (Appellant's Testimony)

6. Social Security Administration ("SSA") informed the Appellant that they will no longer deduct $150.00 from his Social Security benefit and reimbursed $150.00 to him in [redacted] 2021 because he has Connecticut Services. (Appellant's Testimony)

7. The Appellant receives a monthly Social Security benefit of $690.00. (Appellant's Testimony)

8. On [redacted], 2021, AHCT issued a notice to the Appellant denying his health care coverage because they updated his health care application and that he did not request coverage for himself. (Exhibit 2: NOA, [redacted]/21; Hearing Summary)

9. The Appellant did not file a new application with AHCT on [redacted] 2021. (AHCT's Testimony)

10. The NOA dated [redacted], 2021, indicates that the Appellant does not qualify for health care coverage but does not specifically state that the Appellant's HUSKY D coverage was terminated. (Exhibit 2)

11. On [redacted], 2021, AHCT discontinued the Appellant's HUSKY D coverage effective [redacted] 2021 because the Appellant aged out of HUSKY D and his Pandemic Medicaid extension had ended. (AHCT's Testimony)

12. AHCT discontinues HUSKY D extension coverage by updating the record to show that the individual did not request health care coverage. (AHCT'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] 2021. Therefore, this decision is due not later than [redacted] 2021. (Hearing Record)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("Conn. Gen. Stats.") 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. Stats. 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. Title 45 C.F.R. § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

5. Title 45 C.F.R. § 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.

6. Title 42 C.F.R. § 435.119 provides that Medicaid health coverage is available for individuals age 19 or older and under age 65 at or below 133 percent of the Federal Poverty Limit ("FPL").

   (b). Effective January 1, 2014, the agency must provide Medicaid to individuals who:
   1) Are age 19 or older and under age 65;
   2) Are not pregnant;
   3) Are not entitled to or enrolled for Medicare benefits under part A or B of the title XVIII of the Act
   4) Are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part; and
   5) Have household income that is at or below 133 percent FPL for the applicable family size.

   The Appellant is not under age 65. AHCT correctly determined that the Appellant does not qualify for HUSKY D.

   The Appellant is enrolled in Medicare part A and part B benefits. AHCT correctly determined that the Appellant does not qualify for HUSKY D.

7. Title 42 C.F.R. § 433.10(b) provides in relevant part for the *Federal medical assistance percentage (FMAP)—Computations.* The FMAP is determined by the formula described in section 1905(b) of the Act…

8. Title 42 C.F.R. § 433.400 provides for continued enrollment for temporary FMAP increase during the Public Health Emergency for COVID-19. (a) *Minimum essential coverage (MEC)* has the meaning provided under section 5000A(f)(1) of the Internal Revenue Code and implementing regulations at 26 CFR 1.5000A-2 and includes minimum essential coverage determined by the Secretary under 26 CFR 1.5000A-2(f).

9. Title 26 C.F.R. § 1.5000A-2(a) provides that in general, minimum essential *coverage* means coverage under a government-sponsored program (described in paragraph (b) of this section), an eligible employer-sponsored

plan (described in paragraph (c) of this section), a plan in the individual market (described in paragraph (d) of this section), a grandfathered health plan (described in paragraph (e) of this section), or other health benefits coverage (described in paragraph (f) of this section). Minimum essential coverage does not include coverage described in paragraph (g) of this section. All terms defined in this section apply for purposes of this section and §1.5000A-1 and §§1.5000A-3 through 1.5000A-5.

10. Title 42 C.F.R. § 433.400(b) provides that the definition of Medicare Savings Program means the coverage of Medicare premiums and cost sharing furnished to individuals described in, and determined by the state to be eligible under, section 1902(a)(10)(E)(i), 1902(a)(10)(E)(iii), or 1902(a)(10)(E)(iv) of the Act.

11. Title 42 C.F.R. § 433.400(c)(2) provides Except as provided in paragraph (d) of this section, for all beneficiaries validly enrolled for benefits under the state plan, a waiver of such plan, or a demonstration project under section 1115(a) of the Act as of or after March 18, 2020, the state must maintain the beneficiary's enrollment as follows, through the end of the month in which the public health emergency for COVID-19 ends:

    (i)(A) provides for beneficiaries whose Medicaid coverage meets the definition of MEC in paragraph (b) of this section as of or after March 18, 2020, the state must continue to provide Medicaid coverage that meets the definition of MEC, except as provided in paragraph (c)(2)(i)(B) of this section.

    (i)(B) provides for beneficiaries described in paragraph (c)(2)(i)(A) whom the state subsequently determines are eligible for coverage under a Medicare Savings Program eligibility group, the state satisfies the requirement described in paragraph (c)(2) of this section if it furnishes the medical assistance available through the Medicare Savings Program.

The Appellant is eligible for coverage under the Medicare Savings Program eligibility group.

AHCT correctly determined Minimum Essential Coverage ("MEC") is provided through the Medicare Savings Program.

AHCT correctly determined that the Appellant is not eligible for continued Medicaid coverage.

On [redacted] 2021, AHCT correctly discontinued the Appellant's HUSKY D Medicaid coverage effective [redacted] 2021.

DECISION

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

Carla Hardy
Carla Hardy
Hearing Officer

Pc: Sabrina Solis, AHCT
Becky Brown, AHCT
Mike Towers, AHCT

Modified Adjusted Gross Income (MAGI) Medicaid and Children's Health Insurance Program (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.

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, 165 Capitol Avenue, Hartford, CT 06106 or the Commissioner of the Department of Social Services, 55 Farmington Avenue, Hartford, CT 06105. 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.