



**STATE OF WISCONSIN  
Division of Hearings and Appeals**

---

In the Matter of



DECISION

BCS/156937

---

The attached proposed decision of the hearing examiner dated June 17, 2014, is modified as follows and, as such, is hereby adopted as the final order of the Department.

**PRELIMINARY RECITALS**

Pursuant to a petition filed April 17, 2014, under Wis. Stat. § 49.45(5)(a), to review a decision by the Milwaukee Enrollment Services in regard to Medical Assistance (MA)/BadgerCare Plus (BC+), a hearing was held on May 14, 2014, at Milwaukee, Wisconsin.

The issue for determination is whether the Department correctly denied the petitioner's household's BC+ certification due to lack of nonfinancial eligibility for January through March 2014, contrary to a December 2013 Marketplace determination.

There appeared at that time and place the following persons:

**PARTIES IN INTEREST:**

Petitioner:



Respondent:

Department of Health Services  
1 West Wilson Street, Room 651  
Madison, Wisconsin 53703

By: Katherine May, HSPC Sr.  
Milwaukee Enrollment Services  
1220 W Vliet St, Room 106  
Milwaukee, WI 53205

**ADMINISTRATIVE LAW JUDGE:**

Nancy J. Gagnon (telephonically)  
Division of Hearings and Appeals

## FINDINGS OF FACT

1. Petitioner (CARES # [REDACTED]) is a resident of Milwaukee County.
2. Prior to passage of 2013 Wisconsin Act 20, “childless adults” were essentially ineligible (*i.e.*, on a waiting list) for any form of Medicaid unless they were elderly, blind or disabled. Put another way, low income alone would not cause a Wisconsin resident to receive any form of Medicaid, including BC+. With the passage of 2013 Wisconsin Act 20 effective July 2, 2013, any childless adult under age 65 with family income at or below 100% of the federal poverty line was BC+ eligible beginning January 1, 2014. *See*, 2013 Wisconsin Act 20, §§ 1046 and 9418(7).
3. The petitioner had private insurance that ended in 2013, as it was deemed inadequate under the Affordable Care Act. He applied for Wisconsin Medicaid/BC+ (hereinafter, BC+) through the federal Marketplace on **December 23, 2013** (ACA Application # [REDACTED]). On the same date, the Marketplace issued a written notice to him, advising that he and his wife were eligible for “Medicaid”/BC+ in Wisconsin. The Marketplace therefore refused to allow the petitioner to purchase subsidized insurance in the Marketplace, due to the BC+ eligibility.
4. On December 21, 2013, the Wisconsin Legislature and governor changed the Wisconsin Statutes such that “childless adults” would not be eligible for BC+ until April 1, 2014. *See*, 2013 Wis. Act 116.
5. Because the petitioner had heard nothing from Wisconsin by January 8, 2014, he filed another application for BC+, this time on the Wisconsin ([access.wi.gov](http://access.wi.gov)) website on January 8. He sought eligibility as a childless adult effective January 1, 2014.
6. The petitioner also conversed telephonically with a [REDACTED] on January 7, and a federal Marketplace supervisor, [REDACTED], on January 8, 2014. They advised that the Marketplace had the December application, and gave no indication that BC+ coverage would not be provided. *See*, federal interaction ID # [REDACTED].
7. Due to last minute state law changes and delays in receiving information from the federal Marketplace, Wisconsin’s computer system was not ready to determine the petitioner’s eligibility until mid-February 2014.
8. On March 5, 2014, the Department issued written notice to the petitioner, advising that he and his wife would be eligible for BC+ beginning April 1, 2014. The notice also advised that the petitioner was not eligible for BC+ for December 2013 through January 2014, due to lack of nonfinancial eligibility. The petitioner appealed.
9. On March 24, 2014, the Department issued written notice to the petitioner, advising that he and his wife would not be eligible, effective May 1, 2014. The basis for discontinuance was excess income. The petitioner’s wife began employment in April 2014, so the household does not contest the discontinuation of BC+ for May 2014 onward.
10. The adjusted gross income relied upon by the Department in its determination was \$1,458.00 in monthly wages from [REDACTED] DDS. This income figure was incorrect; the household’s adjusted gross income was under 100% FPL for a household of two from January through March 2014.

## DISCUSSION

### I.

BadgerCare Plus is a Wisconsin variant of the MA program, for non-elderly, non-disabled Wisconsin residents. The program’s nonfinancial eligibility standards were broadened effective April 1, 2014, to

include adults who do not have minor children in their home. Wis. Stat. § 49.45(23); 2013 Wisconsin Act 116, § 29, for effective date; *BadgerCare Plus Eligibility Handbook (BCPEH)*, § 2.1, online at <http://www.emhandbooks.wisconsin.gov/bcplus/bcplus.htm> (viewed in June 2014). There is no dispute that the petitioner met the nonfinancial eligibility tests for the program effective April 1, 2014. As of the state government's action on December 21, 2013, he did not meet the nonfinancial eligibility tests for the program from January 1 through March 31, 2014.

The petitioner must also pass an income test. An eligible applicant cannot have adjusted gross income exceeding 100% of the federal poverty level (FPL). Wis. Stat. § 49.45(23)(a); *BCPEH*, § 16.1. The 100% FPL amount is \$972.50 monthly for a household of one, and \$1,310.83 for a household of two persons in 2014. *Id.*, § 50.1. The petitioner's household of two met the income test throughout the January through April 2014 period.

The Department calculated a gross income amount for the petitioner of \$1,458, based on the average of two submitted paystubs. From gross income, the Department is allowed to subtract only those income tax deductions listed on lines #16 - #19 of the federal 1040A tax return, subject to modifications listed at 42 C.F.R. § 435.603(e). The petitioner did not identify any of these adjusted gross income deductions as being applicable here.

The petitioner disagreed with the Department's income calculation pertaining to the gross income calculation. He testified that February 2014 was an atypically high earnings month. His wife, a student at the time, worked for a short period to help out a friend. She then returned to her studies, and no income. The petitioner's testimony was supported by the year-to-date pay totals shown on the submitted paystubs. Accordingly, I found that the petitioner's adjusted gross income was \$432.00 monthly, based on a Year-to-Date paystub extrapolation. This does not exceed 100% FPL for a household of two persons.

## II. DETERMINATION VS. ASSESSMENT STATUS

The remaining issue in the case is whether the federal Marketplace's notice to the petitioner on December 23, 2013, advising that his household was eligible for Medicaid, is controlling for the January through March 2014 period. The petitioner argues that it should control, and that his household should be certified for BC+ from January through March, 2014.

Legally (if not in actual practice), the federal Marketplace was to offer private health insurance plans, plus premium subsidies for persons with income between 100% and 400% FPL, beginning October 1, 2013. Such purchased coverage could begin effective January 1, 2014. After several unsuccessful efforts, the petitioner entered the Marketplace on December 23, 2013, trying to buy private insurance.

A Marketplace application is considered to be a simultaneous application for either a private insurance premium subsidy, or state Medicaid/BC+. The BC+ eligibility determination is made first; if the applicant is BC+ eligible, the Marketplace will not determine a premium subsidy. Here, the Marketplace determined on December 23 that the petitioner's household was BC+ eligible effective January 1, 2014, and therefore would not determine a premium subsidy. If the Marketplace had made its decision on or before December 20, its decision would have been consistent with Wisconsin law. *See*, 2013 Wisconsin Act 20, §§ 1046 and 9418(7); *BEPS/DFS Operations Memo*, No. 13-32(10/14/2013). Wisconsin law changed on December 21, so by December 23 the Marketplace decision was not consistent with Wisconsin law.

Thus, if the language of the Wisconsin statutes from December 21, 2013 through the present is applied, the petitioner's household could not be eligible for BC+ before April 1, 2014, because the household contained only childless adults (*i.e.*, they lacked nonfinancial eligibility). Significantly, however,

Wisconsin chose to be a “determination state” from October 1 through December 31, 2013. Wisconsin became an “assessment state” from January 1, 2014 onward. For determination states, the Marketplace makes a Medicaid eligibility decision on each application, and that decision is binding on the state for a period of time. For assessment states, the Marketplace makes a guess as to each Medicaid applicant’s eligibility, and routes applications that appear likely to qualify for Medicaid to the state for a final decision by the state on the person’s eligibility. 45 C.F.R. § 155.302(b). If the petitioner had filed his BC+ application on or after January 1, 2014, the Marketplace’s incorrect finding of eligibility would not have been binding on Wisconsin, because it was now an assessment state.

The petitioner is essentially arguing that the Marketplace’s incorrect December decision that he was eligible for BC+ should be binding because Wisconsin was a determination state at the time. The state policy documents issued in January 2014 all advise the state/consortia/county workers to not make a childless adult eligible for BC+ until April 1, 2014, even if that adult filed a Marketplace application prior to January 1. *See, BEPS/DFS Operations Memo*, No. 14-01, p.7.

The code of federal regulations does of course have some language relevant to this issue. With the petitioner’s consent, the hearing record was held open for a state-level department analyst to provide additional review of this case. In upholding the Department’s decision to deny BC+ for January through March (email dated June 11, 2014), she relied upon the following federal code language:

**§155.305 Eligibility standards.**

...  
(c) *Eligibility for Medicaid.* The Exchange *must determine an applicant eligible for Medicaid if he or she meets the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI-based income*, as certified by the Medicaid agency in accordance with 42 CFR 435.1200(b)(2), has a household income, as defined in 42 CFR 435.603(d), that is at or below the applicable Medicaid MAGI-based income standard as defined in 42 CFR 435.911(b)(1) ...

[emphasis added]

45 C.F.R. § 155.305(c). In the federal code, “Exchange” equals the Marketplace. Because the petitioner did not meet the nonfinancial eligibility test for BC+, the Marketplace should not have found him eligible.

However, the Marketplace *did* find him BC+ eligible. So, what then? The state agency and federal government were supposed to enter into a memorandum of agreement for Marketplace/state coordination. 42 C.F.R. § 435.1200(b)(3). The code also says this:

(c) *Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program.* If the agency has entered into an agreement in accordance with §431.10(d) of this subchapter under which the Exchange ... makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange or other program, the agency must –

- (1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;
- (2) Comply with the provisions of §435.911 of this part to the same extent as if the application had been submitted to the Medicaid agency; and
- (3) Comply with the provisions of §431.10 of this subchapter to ensure it maintains oversight for the Medicaid program.

*Id.*, § 435.1200(c).

The state and the federal government had reached an agreement for effectuating the transition of the BC+ program, evidenced in an exchange of letters in December 2013, although no formal memorandum of agreement was ever signed between the two.

The cross-referenced §435.911 declares:

**§435.911 Determination of eligibility.**

...

(b)(1) *Applicable modified adjusted gross income standard* means 133 percent of the Federal poverty level or, if higher—

(i) In the case of parents... ;

(ii) In the case of pregnant women, ... ;

(iii) In the case of individuals under age 19, the income standard ... ;

(iv) The income standard established under §435.218(b)(1)(iv) of this part, if the State has elected to provide coverage under such section and, if applicable, coverage under the State's phase-in plan has been implemented for the individual whose eligibility is being determined.

(2) [Reserved]

(c) *For each individual* who has submitted an application described in §435.907 or whose eligibility is being renewed in accordance with §435.916 *and who meets the non-financial requirements for eligibility ... , the State Medicaid agency must comply with the following—*

(1) The agency must, promptly and without undue delay consistent with timeliness standards established under §435.912, *furnish Medicaid to each such individual* who is under age 19, pregnant, or age 19 or older and under age 65 and not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, and whose household income is at or below the applicable modified adjusted gross income standard.

42 C.F.R. § 435.911. I construe this to mean that, even for a determination state, a Marketplace decision that incorrectly finds a person eligible for Medicaid is not enforceable, if the Marketplace was wrong about *nonfinancial* eligibility. Only financial eligibility errors would be imposed upon the state.

III. INITIAL ENROLLMENT PERIOD.

It is a basic rule of statutory construction that the specific controls the general. There is a specific code provision regarding coordination during the first Exchange enrollment period. The code offers this:

**§435.1205 Alignment with exchange initial open enrollment period.**

(a) *Definitions.* For purposes of this section—

*Eligibility based on MAGI* means Medicaid eligibility based on the eligibility requirements which will be effective under the State plan, or waiver of such plan, as of January 1, 2014, consistent with §§435.110 through 435.119, 435.218 and 435.603.

**(b) Medicaid agency responsibilities to achieve coordinated open enrollment.** For the period beginning October 1, 2013 through December 31, 2013, the agency must:

(1) Accept all of the following:

(i) The single streamlined application described in §435.907. [*state level application*]

(ii) Via secure electronic interface, an electronic account transferred from another insurance affordability program. [*Marketplace filing*]

**(2) For eligibility based on MAGI, comply with the terms of §435.1200 of this part, such that—**

**(i) For each electronic account transferred to the agency under paragraph (c)(1)(ii) of this section, the agency consistent with either of the following:**

**(A) Section 435.1200(c), accepts a determination of Medicaid eligibility based on MAGI, made by another insurance affordability program.**

**(B) Section 435.1200(d), determines eligibility for Medicaid based on MAGI.**

**(ii) Consistent with §435.1200(e), for each single streamlined application submitted directly to the agency under paragraph (b)(1)(i) of this section—**

**(A) Determine eligibility based on MAGI; and**

**(B) For each individual determined not Medicaid eligible based on MAGI, determine potential eligibility for other insurance affordability programs, based on the requirements which will be effective for each program, and transfer the individual's electronic account to such program via secure electronic interface.**

**(iii) Provide notice and fair hearing rights, in accordance with §435.917 of this part, part 431 subpart E of this chapter, and §435.1200 for those determined ineligible for Medicaid.**

**(3) For each individual determined eligible based on MAGI in accordance with paragraph (c)(2) of this section—**

**(i) Provide notice, including the effective date of eligibility, to such individual, consistent with §435.917 of this part, and furnish Medicaid.**

(emphasis added)

42 C.F.R. §435.1205. As if this was not complicated enough, it appears to me that the above code section has a drafting error – use of “(c)(1)(ii)” rather than “(b)(1)(ii)” at §435.1205(b)(2)(i) and “(c)2” rather than “(b)2” at §435.1205(b)(3). There is no “(c)” in this section.

MAGI is a financial test, which the petitioner's household passed. However, for a determination of eligibility based on MAGI, 42 C.F.R. §435.1205 requires compliance with §435.1200; 42 C.F.R. §435.1205(b)(2). Under 42 C.F.R. § 1205(b)(2)(i)(A), before the state must accept a determination from the Marketplace that an applicant is eligible for medical assistance based on MAGI, the application must comply with 42 C.F.R. 1200(c). Under 42 C.F.R. 1200 (c)(2), the state must accept the application as if it had been made directly to the state, but only if the application complies with the requirements in 42 C.F.R. § 435.911. Under 42 C.F.R. 435.911(c), quoted above, an applicant must meet the nonfinancial eligibility requirements before the state must provide medical assistance benefits. As noted above, the Petitioner did not meet the requirements for nonfinancial eligibility prior to April 1, 2014. Thus, the Department was not required to provide medical assistance and the Petitioner was not eligible for BadgerCare+ for the period from January 1 to March 31, 2014.

Finally, it is important to remember that the program that the Marketplace incorrectly found the Petitioner eligible for, medical assistance for childless adults at or below the federal poverty line, was not available in Wisconsin until April 1, 2014. Pursuant to 2013 Act 116, childless adults such as the Petitioner were not eligible for BadgerCare+ before that date. Any determination by the Marketplace that the Petitioner was eligible for BadgerCare+, as a matter of state law, could only be effective when the program actually expanded to include childless adults such as the Petitioner. Nothing in the federal law requires the state to create a unique eligibility category for the Petitioner due to an error committed by the federal Marketplace.

#### **CONCLUSIONS OF LAW**

1. The petitioner was not eligible for BadgerCare+ enrollment for the period between January 1, 2014 and March 31, 2014.
2. The determination by the Marketplace that the petitioner was eligible for BadgerCare+ was only binding on the state once the BadgerCare+ program became available for childless adults at or below 100% of the federal poverty level.

**THEREFORE, it is**

**ORDERED**

That the Petitioner's appeal should be, and hereby is, Dismissed.

#### **REQUEST FOR A REHEARING**

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision**. Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 5005 University Avenue, Suite 201, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST". Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

**APPEAL TO COURT**

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 1 West Wilson Street, Room 651, Madison, WI, 53703, **and** on those identified in this decision as "PARTIES IN INTEREST" **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing request (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of  
Madison, Wisconsin, this 11<sup>th</sup> day  
of August, 2014.

*Kevin E. Moore*

Kevin E. Moore, Deputy Secretary  
Department of Health Services



FH  
8159242280

**STATE OF WISCONSIN  
Division of Hearings and Appeals**

---

In the Matter of



PROPOSED DECISION

BCS/156937

---

**PRELIMINARY RECITALS**

Pursuant to a petition filed April 17, 2014, under Wis. Stat. § 49.45(5)(a), to review a decision by the Milwaukee Enrollment Services in regard to Medical Assistance (MA)/BadgerCare Plus (BC+), a hearing was held on May 14, 2014, at Milwaukee, Wisconsin.

The issue for determination is whether the Department correctly denied the petitioner's household's BC+ certification due to lack of nonfinancial eligibility for January through March 2014, contrary to a December 2013 Marketplace determination.

There appeared at that time and place the following persons:

**PARTIES IN INTEREST:**

Petitioner:



Respondent:

Department of Health Services  
1 West Wilson Street, Room 651  
Madison, Wisconsin 53703

By: Katherine May, HSPC Sr.  
Milwaukee Enrollment Services  
1220 W Vliet St, Room 106  
Milwaukee, WI 53205

**ADMINISTRATIVE LAW JUDGE:**

Nancy J. Gagnon (telephonically)  
Division of Hearings and Appeals

**FINDINGS OF FACT**

1. Petitioner (CARES # ) is a resident of Milwaukee County.

2. Prior to passage of 2013 Wisconsin Act 20, “childless adults” were essentially ineligible (*i.e.*, on a waiting list) for any form of Medicaid unless they were elderly, blind or disabled. Put another way, low income alone would not cause a Wisconsin resident to receive any form of Medicaid, including BC+. With the passage of 2013 Wisconsin Act 20 effective July 2, 2013, any childless adult under age 65 with family income at or below 100% of the federal poverty line was BC+ eligible beginning January 1, 2014. *See*, 2013 Wisconsin Act 20, §§ 1046 and 9418(7).
3. The petitioner had private insurance that ended in 2013, as it was deemed inadequate under the Affordable Care Act. He applied for Wisconsin Medicaid/BC+ (hereinafter, BC+) through the federal Marketplace on **December 23, 2013** (ACA Application # [REDACTED]). On the same date, the Marketplace issued a written notice to him, advising that he and his wife were eligible for “Medicaid”/BC+ in Wisconsin. The Marketplace therefore refused to allow the petitioner to purchase subsidized insurance in the Marketplace, due to the BC+ eligibility.
4. On December 21, 2013, the Wisconsin Legislature and governor changed the Wisconsin Statutes such that “childless adults” would not be eligible for BC+ until April 1, 2014. *See*, 2013 Wis. Act 116.
5. Because the petitioner had heard nothing from Wisconsin by January 8, 2014, he filed another application for BC+, this time on the Wisconsin ([access.wi.gov](http://access.wi.gov)) website on January 8. He sought eligibility as a childless adult effective January 1, 2014.
6. The petitioner also conversed telephonically with a [REDACTED] on January 7, and a federal Marketplace supervisor, [REDACTED], on January 8, 2014. They advised that the Marketplace had the December application, and gave no indication that BC+ coverage would not be provided. *See*, federal interaction ID # [REDACTED].
7. Due to last minute state law changes and delays in receiving information from the federal Marketplace, Wisconsin’s computer system was not ready to determine the petitioner’s eligibility until mid-February 2014.
8. On March 5, 2014, the Department issued written notice to the petitioner, advising that he and his wife would be eligible for BC+ beginning April 1, 2014. The notice also advised that the petitioner was not eligible for BC+ for December 2013 through January 2014, due to lack of nonfinancial eligibility. The petitioner appealed.
9. On March 24, 2014, the Department issued written notice to the petitioner, advising that he and his wife would not be eligible, effective May 1, 2014. The basis for discontinuance was excess income. The petitioner’s wife began employment in April 2014, so the household does not contest the discontinuation of BC+ for May 2014 onward.
10. The adjusted gross income relied upon by the Department in its determination was \$1,458.00 in monthly wages from Debra Palmer, DDS. This income figure was incorrect; the household’s adjusted gross income was under 100% FPL for a household of two from January through March 2014.

## DISCUSSION

### I.

BadgerCare Plus is a Wisconsin variant of the MA program, for non-elderly, non-disabled Wisconsin residents. The program’s nonfinancial eligibility standards were broadened effective April 1, 2014, to include adults who do not have minor children in their home. Wis. Stat. § 49.45(23); 2013 Wisconsin Act 116, § 29, for effective date; *BadgerCare Plus Eligibility Handbook (BCPEH)*, § 2.1, online at <http://www.emhandbooks.wisconsin.gov/bcplus/bcplus.htm> (viewed in June 2014). There is no dispute that the petitioner met the nonfinancial eligibility tests for the program effective April 1, 2014. As of the state

government's action on December 21, 2013, he did not meet the nonfinancial eligibility tests for the program from January 1 through March 31, 2014.

The petitioner must also pass an income test. An eligible applicant cannot have adjusted gross income exceeding 100% of the federal poverty level (FPL). Wis. Stat. § 49.45(23)(a); *BCPEH*, § 16.1. The 100% FPL amount is \$972.50 monthly for a household of one, and \$1,310.83 for a household of two persons in 2014. *Id.*, § 50.1. The petitioner's household of two met the income test throughout the January through April 2014 period.

The Department calculated a gross income amount for the petitioner of \$1,458, based on the average of two submitted paystubs. From gross income, the Department is allowed to subtract only those income tax deductions listed on lines #16 - #19 of the federal 1040A tax return, subject to modifications listed at 42 C.F.R. § 435.603(e). The petitioner did not identify any of these adjusted gross income deductions as being applicable here.

The petitioner disagreed with the Department's income calculation pertaining to the gross income calculation. He testified that February 2014 was an atypically high earnings month. His wife, a student at the time, worked for a short period to help out a friend. She then returned to her studies, and no income. The petitioner's testimony was supported by the year-to-date pay totals shown on the submitted paystubs. Accordingly, I found that the petitioner's adjusted gross income was \$432.00 monthly, based on a Year-to-Date paystub extrapolation. This does not exceed 100% FPL for a household of two persons.

## II. DETERMINATION VS. ASSESSMENT STATUS

The remaining issue in the case is whether the federal Marketplace's notice to the petitioner on December 23, 2013, advising that his household was eligible for Medicaid, is controlling for the January through March 2014 period. The petitioner argues that it should control, and that his household should be certified for BC+ from January through March, 2014.

Legally (if not in actual practice), the federal Marketplace was to offer private health insurance plans, plus premium subsidies for persons with income between 100% and 400% FPL, beginning October 1, 2013. Such purchased coverage could begin effective January 1, 2014. After several unsuccessful efforts, the petitioner entered the Marketplace on December 23, 2013, trying to buy private insurance.

A Marketplace application is considered to be a simultaneous application for either a private insurance premium subsidy, or state Medicaid/BC+. The BC+ eligibility determination is made first; if the applicant is BC+ eligible, the Marketplace will not determine a premium subsidy. Here, the Marketplace determined on December 23 that the petitioner's household was BC+ eligible effective January 1, 2014, and therefore would not determine a premium subsidy. If the Marketplace had made its decision on or before December 20, its decision would have been consistent with Wisconsin law. *See*, 2013 Wisconsin Act 20, §§ 1046 and 9418(7); *BEPS/DFS Operations Memo*, No. 13-32(10/14/2013). Wisconsin law changed on December 21, so by December 23 the Marketplace decision was not consistent with Wisconsin law.

Thus, if the language of the Wisconsin statutes from December 21, 2013 through the present is applied, the petitioner's household could not be eligible for BC+ before April 1, 2014, because the household contained only childless adults (*i.e.*, they lacked nonfinancial eligibility). Significantly, however, Wisconsin chose to be a "determination state" from October 1 through December 31, 2013. Wisconsin became an "assessment state" from January 1, 2014 onward. For determination states, the Marketplace makes a Medicaid eligibility decision on each application, and that decision is binding on the state for a period of time. For assessment states, the Marketplace makes a guess as to each Medicaid applicant's

eligibility, and routes applications that appear likely to qualify for Medicaid to the state for a final decision by the state on the person's eligibility. 45 C.F.R. § 155.302(b). If the petitioner had filed his BC+ application on or after January 1, 2014, the Marketplace's incorrect finding of eligibility would not have been binding on Wisconsin, because this was now an assessment state.

The petitioner is essentially arguing that the Marketplace's incorrect December decision that he was eligible for BC+ should be binding because Wisconsin was a determination state at the time. The state policy documents issued in January 2014 all advise the state/consortia/county workers to not make a childless adult eligible for BC+ until April 1, 2014, even if that adult filed a Marketplace application prior to January 1. *See, BEPS/DFS Operations Memo*, No. 14-01, p.7.

The code of federal regulations does of course have some language relevant to this issue. With the petitioner's consent, the hearing record was held open for a state-level department analyst to provide additional review of this case. In upholding the Department's decision to deny BC+ for January through March (email dated June 11, 2014), she relied upon the following federal code language:

**§155.305 Eligibility standards.**

...

(c) *Eligibility for Medicaid.* The Exchange *must determine an applicant eligible for Medicaid if he or she meets the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI-based income*, as certified by the Medicaid agency in accordance with 42 CFR 435.1200(b)(2), has a household income, as defined in 42 CFR 435.603(d), that is at or below the applicable Medicaid MAGI-based income standard as defined in 42 CFR 435.911(b)(1) ...

[emphasis added]

45 C.F.R. § 155.305(c). In the federal code, "Exchange" equals the Marketplace. Because the petitioner did not meet the nonfinancial eligibility test for BC+, the Marketplace should not have found him eligible.

However, the Marketplace *did* find him BC+ eligible. So, what then? The state agency and federal government were supposed to enter into a memorandum of agreement for Marketplace/state coordination; as far I as know, that has not happened, due to federal delay. 42 C.F.R. § 435.1200(b)(3). The code also says this:

(c) *Provision of Medicaid for individuals found eligible for Medicaid by another insurance affordability program.* If the agency has entered into an agreement in accordance with §431.10(d) of this subchapter under which the Exchange ... makes final determinations of Medicaid eligibility, for each individual determined so eligible by the Exchange or other program, the agency must –

- (1) Establish procedures to receive, via secure electronic interface, the electronic account containing the determination of Medicaid eligibility;
- (2) Comply with the provisions of §435.911 of this part to the same extent as if the application had been submitted to the Medicaid agency; and
- (3) Comply with the provisions of §431.10 of this subchapter to ensure it maintains oversight for the Medicaid program.

*Id.*, § 435.1200(c). The cross-referenced §435.911 declares:

**§435.911 Determination of eligibility.**

...

(b)(1) *Applicable modified adjusted gross income standard* means 133 percent of the Federal poverty level or, if higher—

(i) In the case of parents... ;

(ii) In the case of pregnant women, ... ;

(iii) In the case of individuals under age 19, the income standard ... ;

(iv) The income standard established under §435.218(b)(1)(iv) of this part, if the State has elected to provide coverage under such section and, if applicable, coverage under the State's phase-in plan has been implemented for the individual whose eligibility is being determined.

(2) [Reserved]

(c) *For each individual* who has submitted an application described in §435.907 or whose eligibility is being renewed in accordance with §435.916 *and who meets the non-financial requirements for eligibility ... , the State Medicaid agency must comply with the following—*

(1) The agency must, promptly and without undue delay consistent with timeliness standards established under §435.912, *furnish Medicaid to each such individual* who is under age 19, pregnant, or age 19 or older and under age 65 and not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, and whose household income is at or below the applicable modified adjusted gross income standard.

42 C.F.R. § 435.911. I construe this to mean that, even for a determination state, a Marketplace decision that incorrectly finds a person eligible for Medicaid is not enforceable, if the Marketplace was wrong about *nonfinancial* eligibility. Only financial eligibility errors would be imposed upon the state.

### III. INITIAL ENROLLMENT PERIOD.

However, that does not end the inquiry for the instant case. It is a basic rule of statutory construction that the specific controls the general. There is a specific code provision regarding coordination during the first Exchange enrollment period. The code offers this:

**§435.1205 Alignment with exchange initial open enrollment period.**

(a) *Definitions.* For purposes of this section—

*Eligibility based on MAGI* means Medicaid eligibility based on the eligibility requirements which will be effective under the State plan, or waiver of such plan, as of January 1, 2014, consistent with §§435.110 through 435.119, 435.218 and 435.603.

**(b) Medicaid agency responsibilities to achieve coordinated open enrollment.** For the period beginning October 1, 2013 through December 31, 2013, the agency must

(1) Accept all of the following:

(i) The single streamlined application described in §435.907. [*state level application*]

(ii) Via secure electronic interface, an electronic account transferred from another insurance affordability program. [*Marketplace filing*]

**(2) For eligibility based on MAGI, comply with the terms of §435.1200 of this part, such that—**

**(i) For each electronic account transferred to the agency under paragraph (c)(1)(ii) of this section, the agency consistent with either of the following:**

**(A) Section 435.1200(c), accepts a determination of Medicaid eligibility based on MAGI, made by another insurance affordability program.**

**(B) Section 435.1200(d), determines eligibility for Medicaid based on MAGI.**

(ii) Consistent with §435.1200(e), for each single streamlined application submitted directly to the agency under paragraph (b)(1)(i) of this section—

**(A) Determine eligibility based on MAGI; and**

**(B) For each individual determined not Medicaid eligible based on MAGI, determine potential eligibility for other insurance affordability programs, based on the requirements which will be effective for each program, and transfer the individual's electronic account to such program via secure electronic interface.**

(iii) Provide notice and fair hearing rights, in accordance with §435.917 of this part, part 431 subpart E of this chapter, and §435.1200 for those determined ineligible for Medicaid.

**(3) For each individual determined eligible based on MAGI in accordance with paragraph (c)(2) of this section—**

**(i) Provide notice, including the effective date of eligibility, to such individual, consistent with §435.917 of this part, and furnish Medicaid.**

(emphasis added)

42 C.F.R. §435.1205. As if this was not complicated enough, it appears to me that the above code section has a drafting error – use of “(c)(1)(ii)” rather than “(b)(1)(ii)” at §435.1205(b)(2)(i) and “(c)2” rather than “(b)2” at §435.1205(b)(3). There is no “(c)” in this section.

I see no language that rules out an incorrect nonfinancial eligibility decision by the Marketplace from being imposed upon a determination state for an application taken between October and December. MAGI is a financial test, which the petitioner's household passed. Thus, I conclude that the Department should have certified the MAGI-eligible petitioner, based on his December

2013 Marketplace application determination of eligibility, for the January through March 2014 period. Because this Decision conflicts with Department policy, it is being sent in Proposed status.

**CONCLUSIONS OF LAW**

1. The petitioner’s household income did not exceed the relevant limit for BC+ eligibility from January through March, 2014.
2. The Department incorrectly denied BC+ certification to the petitioner’s household for January through March 2014, based on his December 2013 Marketplace BC+ application, at which time Wisconsin was in determination state status.

**THEREFORE, it is**

**ORDERED**

That, if this Proposed Decision is adopted by the Secretary or her designee, the petition is remanded to the Department with instructions to certify the petitioner for BC+) for January through March, 2014 period, within 10 days of the date of the Final Decision.

**NOTICE TO RECIPIENTS OF THIS DECISION:**

This is a Proposed Decision of the Division of Hearings and Appeals. IT IS NOT A FINAL DECISION AND SHOULD NOT BE IMPLEMENTED AS SUCH. If you wish to comment or object to this Proposed Decision, you may do so in writing. It is requested that you briefly state the reasons and authorities for each objection together with any argument you would like to make. Send your comments and objections to the Division of Hearings and Appeals, P.O. Box 7875, Madison, WI 53707-7875. Send a copy to the other parties named in the original decision as 'PARTIES IN INTEREST.'

All comments and objections must be received no later than 15 days after the date of this decision. Following completion of the 15-day comment period, the entire hearing record together with the Proposed Decision and the parties' objections and argument will be referred to the Secretary of the for final decision-making.

The process relating to Proposed Decision is described in Wis. Stat. § 227.46(2).

Given under my hand at the City of Madison, Wisconsin, this 17 day of June, 2014



Nancy J. Gagnon  
Administrative Law Judge  
Division of Hearings and Appeals