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

[redacted] 2016
Signature Confirmation

Client ID # [redacted]
Application # [redacted]
Hearing Request # 772377

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2016, the Health Insurance Exchange Access Health CT ("AHCT") as an agent of the Department of Social Services ("the Department") sent a notice to [redacted] (the "Appellant") granting HUSKY B-Band 1 healthcare coverage for her son, [redacted] 2016.

On [redacted] 2016, the Appellant requested a hearing to contest the failure to approve the HUSKY A healthcare coverage.

On [redacted] 2016, the Office of Legal Counsel, Regulations, and Administrative Hearings (the "OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2016.

On [redacted] 2016, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statues, OLCRAH held an administrative hearing. The following individuals were present at the hearing:

[redacted], Appellant
Ivan Del Valle, AHCT Representative
Carla Hardy, Hearing Officer

The Hearing Record was left open for the submission of additional information. The record closed on [redacted] 2016.

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly denied Medicaid/HUSKY A coverage and granted HUSKY B- band 1 coverage.

FINDINGS OF FACT

1. The Appellant's household consists of herself and her child [redacted] (Appellant's Testimony).

2. On [redacted] 2016, the Appellant applied for HUSKY A healthcare coverage for her child only. She reported monthly income totaling $2,965.28 (Exhibit A: Application # [redacted], Hearing Record).

3. The Appellant's child is 10 months (DOB [redacted] 15) old (Exhibit A).

4. The Appellant's income is self-attested (AHCT's Testimony).

5. On [redacted] 2016, the Appellant supplied this hearing officer with the following four paystubs: [redacted]/16, $689.60; [redacted]16, $689.60; [redacted]/16, $689.60; [redacted]/16, $655.12 (Appellant's Exhibit 1: Paystubs).

6. The Appellant contributes two percent of her gross income to a 401k plan (Appellant's Testimony).

7. AHCT was not aware of the Appellant's contributions to her 401k plan (AHCT's Testimony).

8. The Federal Poverty Limit ("FPL") for a two person household is $16, 020.00 per year or 1,335.00 ($16,020.00/12) per month (Federal Register).

9. The Appellant's child was denied HUSKY A coverage (Exhibit C: Eligibility Determination, Hearing Record).

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. 42 CFR § 435.110(b)(c)(2)(i) provides that the agency must provide Medicaid to parents and caretaker relatives whose income is at or below the income standard established by the agency in the State Plan.

7. 42 CFR § 435.118(b)(2)(ii) provides that the agency must provide Medicaid to children under age 19 whose income is at or below the income standard established by the agency in its State Plan.

8. Title 26 section 62(a)(6) of the United States Code ("USC") provides in part that pension, profit-sharing, and annuity plans of self-employed individuals are not included in adjusted gross income.

9. The Appellant's monthly $59.31 ($2,965.28 x .02) contribution to her 401k plan was incorrectly included in the calculation of her countable income.

10. 42 CFR § 435.603(e) provides in part that MAGI-based income means income calculated using the same financial methodologies used to determine modified adjusted gross income as defined in section 36B(d)(2)(B) of the Code, with the following exceptions—

    (1) An amount received as a lump sum is counted as income only in the month received.
    (2) Scholarships, awards, or fellowship grants used for education purposes and not for living expenses are excluded from income.
    (3) Certain American Indian/Alaska Native distributions.

11. Title 26 of the Internal Revenue Code ("IRC") section 36B(d)(2)(B) provides that the term "modified adjusted gross income" means adjusted gross income increased by –
    (i) any amount excluded from gross income under section 911,
    (ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax, and
    (iii) an amount equal to the portion of the taxpayer's social security benefits (as defined in section 86(d)) which is not included in gross income under section 86 for the taxable year.

12. The Appellant's monthly MAGI totaled $2,905.97 ($2,965.28 - $59.31 (401k contribution)).

13. Public Act 15-5 June Sp. Session, Section 370 (a) provides in part Except as provided in section 17b-277, as amended by this act, and section 17b-292, as amended by public act 15-69 and this act, the medical assistance program shall provide coverage to persons under the age of nineteen with household income up to one hundred ninety-six per cent of the federal poverty level without an asset limit and to persons under the age of nineteen, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding one hundred ninety-six per cent of the federal poverty level without an asset limit, and their parents and needy caretaker relatives, who qualify for coverage under Section 1931 of the Social Security Act, with household income not exceeding one hundred fifty per cent of the federal poverty level without an asset limit.

14. One hundred ninety-six percent of the FPL for a household of two totals $2,616.60 ($1,335.00 x 1.96) per month.

15. 42 CFR §435.603(d)(1)(4) provides for the application of the household's modified adjusted gross income ("MAGI"). The household's income is the sum of the MAGI-based income, as defined in paragraph (e) of this section, of every individual included in the individual's household. Effective January 1, 2014, a state must subtract an amount equivalent to 5 percentage points of the Federal Poverty Level for the applicable family size only to determine the eligibility of an

individual for medical assistance under the eligibility group with the highest income standard using MAGI-based methodologies.

16. Five percent of the FPL for a family of two is $801.00 ($16,020.00 x .05) per year or $66.75 ($801.00/12) per month.

17. The Appellant's countable MAGI totals $2,839.22 ($2,965.28 - $59.31 (401k contribution) - $66.75) per month.

18. The Appellant's monthly income of $2,839.22 exceeds the HUSKY A income limit for persons under the age of nineteen ($2,616.60) in a two person household.

19. The Department was correct to deny Medicaid/HUSKY A and grant HUSKY B-band 1 healthcare coverage.

DISCUSSION

AHCT was unaware that the Appellant was making contributions totaling two percent of her gross income to her 401k plan. These contributions were not deducted from her earnings and slightly inflated her countable income. The Appellant's modified adjusted gross income still exceeded the HUSKY A threshold after taking that 401k deduction into consideration.

The eligibility notice issued on [redacted] 2016 addresses the granting of HUSKY B coverage but does not address the denial of HUSKY A. The Appellant was made aware of the HUSKY A denial and requested a hearing on [redacted] 2016 due to that denial. AHCT correctly denied the HUSKY A coverage since the Appellant's countable MAGI exceeded the threshold for Medicaid/HUSKY A for a family of two.

DECISION

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

Carla Hardy

Carla Hardy
Fair Hearings Officer

Pc: Ivan Del Valle, Health Insurance Exchange Access Health CT

APTC/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 Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (CSR).

MEDICAID AND 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.

There is no right to request reconsideration for denials or reductions of Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (CSR).

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, 55 Elm Street, 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.