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

[redacted] **2017**
Signature Confirmation

Client ID # [redacted]
Application # [redacted]
Hearing Request # 818865

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Health Insurance Exchange Access Health CT ("AHCT") sent a notice to [redacted] (the "Appellant") denying the Children's Health Insurance Program ("CHIP")/HUSKY B healthcare coverage for her son [redacted] (the "Applicant") as he has other credible health coverage.

On [redacted] 2017, the Appellant requested a hearing to contest the denial of the CHIP/HUSKY B healthcare coverage.

On [redacted] 2017, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2017.

On [redacted] 2017, 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 participated in the hearing:

[redacted] Appellant
Judy Boucher, AHCT Representative
Shelley Starr, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT was correct to deny the CHIP/HUSKY B healthcare coverage.

FINDINGS OF FACT

1. The Applicant's household consists of three members that include his mother, (the "Appellant"), his father, and himself, (the " Applicant"). (Exhibit 3: Application; Appellant's testimony).

2. On [redacted] 2017, a change reporting application was submitted requesting health coverage for the minor child (the "Applicant"). (Exhibit 3: Application dated [redacted] 2017)

3. The Applicant has Anthem health coverage through his parent's employer. (Exhibit 3: Application dated [redacted] 2017; Appellant's Testimony)

4. The Applicant has been diagnosed with Autism. His Anthem health coverage does not fully cover all of the services needed for his treatment. (Appellant's Testimony)

5. The Appellant reported self-declared income of $5,400.00 monthly and $72,000.00 yearly. (Hearing Summary; Exhibit 3: Application dated [redacted] 2017)

6. The Department determined that the minor child did not qualify for Husky A because of the income limit for a household size of three and further explored Husky B eligibility for the Applicant. (Department's Testimony; Exhibit 6: Notice dated [redacted] 2017)

7. The Department determined the Applicant was not eligible for Husky B. (Hearing Record)

8. On [redacted] 2017, the Department sent the Appellant a notice informing her that her son did not qualify for Husky B because he has other creditable health coverage. (Exhibit 6: Notice dated [redacted] 2017)

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 § 457.310 provides for the targeted low-income child.
   (a) a targeted low-income child is a child who meets the standards set forth below and the eligibility standards established by the State under §457.320.
   (b) Standards. A targeted low-income child must meet the following standards:
      (1) Financial need standard. A targeted low-income child
         (i) Has a household income, as determined in accordance with §457.315 of this subpart, at or below 200 percent of the Federal poverty level for a family of the size involved.
         (ii) Resides in a State with no Medicaid applicable income level;

(iii) Resides in a State that has a Medicaid applicable income level and has a household income that either-
(A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or
(B) Does not exceed the income level specified for such child to be eligible for medical assistance under policies of the State plan under title XIX on June 1, 1997.

(2) No other coverage standard. A targeted low-income child must not be—
(i) Found eligible or potentially eligible for Medicaid under policies of the State plan (determined through either the Medicaid application process or the screening process described at §457.350; or
(ii) Covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act, unless the plan or health insurance coverage program has been in operation since before July 1, 1997 and is administered by a State that receives no Federal funds for the program's operation. A child is not considered covered under a group health plan or health insurance coverage if the child does not have reasonable geographic access to care under that plan.

The Applicant has other creditable health insurance coverage through Anthem.

The Department was correct to deny the Applicant Husky B healthcare coverage as he does not qualify for Husky B as he has other creditable health coverage.

DECISION

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

Shelley Starr
Hearing Officer

cc: Judy Boucher, Health Insurance Exchange Access Health CT

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, 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 extensions 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.