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]
Request # 825858

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2017, the Health Insurance Exchange, Access Health CT ("AHCT"), sent [redacted] (the "Appellant") a Notice of Action ("NOA) discontinuing his Medicaid Husky D healthcare coverage ("Husky D") for himself and his spouse.

On [redacted] 2017, the Appellant requested an administrative hearing to contest the AHCT's decision to discontinue such benefits.

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-264 and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, Chapter 45 Code of Federal Regulations ("CFR") §§ 155.505(b) and 155.510 and/or 42 CFR § 457.1130, OLCRAH held an administrative hearing by telephone.

The following individuals called in for the hearing:

[redacted] Appellant
[redacted] Appellant's Spouse
Sabrina Solis, Appeals Coordinator and AHCT Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the Appellant's healthcare coverage under the Husky D program effective [redacted] 2017.

FINDINGS OF FACT

1. The Appellant and his spouse [redacted] ("spouse") received medical assistance under the Husky D program. (Hearing Record)

2. The Appellant is sixty-three (63) years old born on [redacted] 1954. (Exhibit 2: Application #[redacted]

3. Beginning February 2017, the Appellant qualifies for Social Security retirement benefits ("SSA") of $1,852.00 per month. (Appellant's Testimony and Exhibit 3: Household Income Verification)

4. In [redacted] 2017, the Appellant received his first check from the Social Security Administration of $1,852.00. Benefits are postpaid. (Exhibit 3: Household Income Verification and Appellant's Testimony)

5. The spouse is sixty-three (63) years old born on [redacted] 1953. (Exhibit 2: Application #[redacted]

6. The spouse works part time for [redacted] (the "employer") as a substitute counselor in the after school extension program for preschoolers. The Appellant's schedule varies from week to week, working three to six hours a week as needed. The Appellant earned the following bi-weekly pays in [redacted] 2017: Check date [redacted] 2017 gross wages $61.29 work hours 4.5; check date [redacted] 2017 gross wages $71.51 work hours 5.25. The Appellant's year to date gross wages as of [redacted] 2017 is $881.91. The school year ended on [redacted] 2017. (Spouse's Testimony)

7. On [redacted] 2017, AHCT received proof of household income from the Appellant. AHCT received two bi-weekly paystubs from the employer for the spouse: check date [redacted] 2017 gross wages $85.13 work hours 6.25 and check date [redacted] 2017 gross wages $81.72 work hours 5.00. AHCT received a note from the Appellant stating he is not employed and not receiving unemployment compensation and a grant letter from the Social Security Administration verifying monthly retirement benefits beginning [redacted] 2017. (Exhibit 3: Proof of Income)

8. On [redacted] 2017, AHCT submitted a telephone change reporting application #[redacted] after receiving proof of household income from the Appellant on [redacted] 2017. (Exhibit 1: Application #[redacted] Exhibit 3: Household Income, and AHCT Representative's Testimony)

9. The Husky D income limit for a household of two is $1,867.00. (Hearing

Summary and AHCT Representative's Testimony)

10. AHCT discontinued the Appellant and his spouse from Husky D effective [redacted] 2017 because the household's gross monthly income of $2,019.00 exceeds the Husky D income limit of $1,867.00. ([redacted]/17 $85.13 + 5/5/17 $81.72 = $166.85 monthly gross wages $166.85 wages + $1,852.00 Social Security = $ 2,018.85) (Hearing Summary, Exhibit 1: Notice of Action [redacted]/17 and AHCT Representative's Testimony)

11. On [redacted] 2017, AHCT issued a notice to the Appellant. The notice stated the Appellant and his spouse are not eligible for medical benefits under the Husky D program because their income of $2,019.00 per month exceeds the Husky D income limit of $1,867.00. (Exhibit 1: Notice of Action [redacted]/17)

12. The Appellant disputes the use of the household's current monthly income to determine eligibility under the Husky D program by AHCT versus the use of the household's 2017 expected annual income. The Appellant received no income for [redacted] 2017 and [redacted] 2017 and the spouse reduced her work hours from permanent part time position to a substitute per diem position. (Appellant's Testimony)

CONCLUSIONS OF LAW

1. Conn. Gen. Stats. § 17b-260 provides that 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. State statute provides that Husky D or Medicaid Coverage for the Lowest Income Populations program means Medicaid provided to non-pregnant low-income adults who are age 18 to sixty-four, as authorized pursuant to section 17b-8. [Conn. Gen. Stats. § 17b-290(16)]

3. State statute provides that 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. (Conn. Gen. Stats. § 17b-264)

4. 45 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: (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.

5. 45 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) or this section that is designated by the Exchange, if the Exchange establishes an appeals process in accordance with the requirements of this subpart.

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

7. 42 CFR § 435.119 provides for coverage for individual age 19 or older and under age 65 at or below 133 percent FPL.

   a. Basis. This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.
   b. Eligibility. 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 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.

8. Effective [redacted] 2017, the Federal Poverty Limit ("FPL") for a household of two is $1,353.00 per month. ($16,240.00 per year / 12 months = $1,353.333 per month) [Federal Register, Vol. 82, No. 19, [redacted] 2017, pp. 8831-8832]

9. The Medicaid income limit for a household of two is $1,799.49 for individuals age 19 or older and under age 65. ($1,353.00 x 133% = $1,799.49 per month)

10. 42 CFR 435.603(a)(2) provides that effective January 1, 2014, the agency must apply the financial methodologies set forth in this section in determining the financial eligibility of all individuals for Medicaid, except for individual identifies in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.

11. 42 CFR § 435.603(b) defines *family size* as the number of persons counted as members of an individual's household. In the case of

determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individual who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expect to deliver.

12. 42 CFR 435.603(f)(1) provides for the basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination of renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons who such individual expects to claim as a tax dependent.

13. 42 CFR § 435.603(c) provides that except as specified in paragraph (i), (j), and (k) of this section, the agency must determine financial eligibility for Medicaid based on "household income" as defined in paragraph (d) of this section.

14. 42 CFR § 435.603(d)(1) provides for household income. Except as provided in paragraphs (d)(2) through (d)(4) of this section, household 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.

    42 CFR 435.603(h)(2) provides for *current beneficiaries*. For individuals who have been determined financially-eligible for Medicaid using the MAGI-based methods set forth in this section, a State may elect in its State plan to base financial eligibility either on current monthly household income and family size or income based on projected annual household income and family size for the remained of the current calendar year.

    Connecticut elected to base financial eligibility for Medicaid on current monthly household income and family size. [Connecticut Medicaid State Plan Amendment Transmittal Number 14-0003MM3, page S10-1, August 25, 2014]

15. 42 CFR § 435.603(d)(4) provides that effective January 1, 2014, in determining the eligibility of an individual using MAGI –based income, 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 in the applicable Title of the Act, but not to determine eligibility for a particular eligibility group.

16. Five percent (5%) of the FPL for a household of two equals $67.65. ($1,353.00 x 5% = $67.65)

17. 42 CFR § 435.603(e) provides for MAGI-based income. For the purposes of this section, 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. Provides for American Indian/Alaska Native exceptions.

18. United States Code ("U.S.C.") § 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.

19. AHCT correctly determined a household of two.

20. AHCT correctly determined the Spouse's monthly gross wages as $166.85.

21. AHCT correctly determined the Appellant's monthly gross income as $1,852.00.

22. AHCT correctly determined the household's monthly gross income as $2,019.00. (166.85 wages + $1,852.00 SSA = $2,018.85)

23. The Appellant's countable income of $1,951.35 exceeds the Medicaid income limit of $1,799.49 for a household of two. ($2,019.00 monthly gross income - $67.65 5% of FPL = $1,951.35 monthly countable income) Refer to Conclusion of Law ("COL") # 9 and #16.

24. AHCT determined the Medicaid Husky D program income limit as $1,868.00 per month by adding 5% of the FPL to the Medicaid income limit for a household of two rather than subtracting the 5% of the FPL from the Appellant's gross wages. Refer to COL # 9 and # 16. (1,799.49 133% of FPL for 2 + $67.65 5% of FPL for 2 = $1,867.14) The result is the same; the Appellant's income exceeds the Medicaid income limit.

25. AHCT correctly determined the Appellant ineligible for Husky D because the Appellant's income exceeds the Husky D income limit for a household of one.

26. AHCT correctly discontinued the Appellant's Medicaid benefits under the Husky D program effective [redacted] 2017.

DECISION

The Appellant's appeal is DENIED.

Lisa A. Nyren
Fair Hearing Officer

CC: Cynthia Perry, Appeals Manager, Health Insurance Exchange, Access Health CT
Judith Boucher, Appeal Supervisor, Health Insurance Exchange, Access Health CT
Sabrina Solis, Appeal Coordinator, 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.