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

[redacted] **2019**
Signature Confirmation

Case ID # [redacted]
Client ID # [redacted]
Request # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Health Insurance Exchange Access Health CT ("AHCT") issued a Notice of Action ("NOA") to [redacted] (the "Appellant") denying Medicaid/HUSKY D healthcare coverage (HUSKY D).

On [redacted] 2018, the Appellant requested an administrative hearing to contest the denial of HUSKY D medical coverage.

On [redacted] 2018, the Office of legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling an administrative hearing for [redacted] 2018.

On [redacted] 2018, 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 ("CFR") §§ 155.505(b) and 155.510 and/or 42 CFR § 457.1130, OLCRAH held an administrative hearing by telephone. The following individuals participated in the hearing:

[redacted] Appellant's Representative
Krystal Sherman-Davis, AHCT Representative
Sybil 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. There are two members in the Appellants household. The Appellant resides with her adult daughter. (Appellant's Testimony, Exhibit 1)

2. The Appellant is [redacted] years old [redacted] and her daughter is [redacted] years old [redacted] (Appellant's Testimony, Exhibit 1)

3. The Appellant is disabled. (Hearing Record)

4. The Appellant has unpaid medical bills with service dates prior to her date of application. (Appellant's Testimony)

5. The Appellant did not apply for help with unpaid medical bills at the time of her application. (AHCT Representative's Testimony)

6. On [redacted] 2018, AHCT received a completed change reporting application in the Health Insurance Exchange ("HIX") system. The reported change was made to renew the household husky coverage. (Exhibit 1: Application # [redacted]18)

7. The Appellant receives a monthly unearned income from Social Security Disability ("SSD") in the amount of $904.00. (Appellant's Testimony, Exhibit1)

8. The Department of Social Services (the "Department") pays the Appellant's Medicare Part B premiums. (AHCT Representative's Testimony)

9. The Appellant's daughter has no income. (Exhibit 1)

10. The Federal Poverty Limit ("FPL") for a household of one is $1,012.00 per month. (Federal Register)

11. On [redacted] 2018, AHCT determined that the Appellant is not eligible for HUSKY D coverage and the Appellant's daughter is eligible for HUSKY D Coverage. (Exhibit 2: Eligibility Determination)

12. On [redacted] 2018, AHCT sent the Appellant's a NOA denying HUSKY D coverage for the Appellant because she receives Medicare benefits and the

Appellant's daughter is eligible for HUSKY D coverage. (Exhibit 3: NOA, [redacted]/18)

13. The Appellant does not want to receive Medicare coverage. (Appellant's Testimony)

14. The Appellant did not apply for any other medical coverage. (Appellant's Testimony)

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) 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. 26 CFR § 1.36B-1(e)(1) provides in general, household income is the sum of-
   (i) A taxpayer's modified adjusted gross income (including the modified adjusted gross income of a child for whom an election under section 1(g)(7) is made for the taxable year);
   (ii) The aggregate modified adjusted gross income of all other individuals who-
      (A) Are included in the taxpayer's family under paragraph (d) of this section; and
      (B) Are required to file a return of tax imposed by section 1 for the taxable year.

7. 42 CFR § 435.603(e) provides 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) American Indian/Alaska Native exceptions.

8. Title 26 of the United States Code ("USC") 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.

9. The State Plan Amendment ("SPA") # 14-0003MM3 provides that financial eligibility will be based on current monthly household income and family size.

10. AHCT correctly determined the Appellant's household income is $904.00 per month ($904.00, SSD).

11. 42 CFR § 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). 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 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.

12. Uniform Policy Manual ("UPM") section 1010.05 provides that the assistance unit must satisfy certain procedural requirements as described in Section 3500 including:
    1. Disclosing or obtaining a Social Security number;
    2. Complying with work requirements when necessary;
    3. Taking certain actions to secure support, when appropriate;
    4. Completing an assignment, when appropriate;
    5. Signing a security mortgage, when appropriate;
    6. Cooperating with the Department as necessary, Cooperation includes:
        a. Taking steps as required by the Department to complete the eligibility determination periodic redetermination of eligibility, interim changes in eligibility or benefit level and Quality Control reviews;
        b. Seeking any potential income or assets for which the unit may be eligible.

13. AHCT correctly determined the Appellant was eligible for Medicare.

14. AHCT correctly determined that the Appellant's is ineligible for HUSKY D coverage because she receives Medicare coverage.

15. AHCT correctly denied Medicaid/HUSKY D healthcare coverage.

DISCUSSION

AHCT correctly denied HUSKY D healthcare coverage for the Appellant because she is entitled to Medicare benefits and receives these benefits. The Appellant expressed that she did not want Medicare, but she is required to apply for any potential income or assets that which she may be eligible. The Appellant did not

apply for any other medical coverage with the Department as a supplement to her Medicare, but it is an option she may pursue at any time.

DECISION

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

Sybil Hardy
Hearing Officer

Pc: Becky Brown, Health Insurance Exchange Access Health CT
Krystal Sherman-Davis, 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.