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

[redacted]
Hearing Request # 136042

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKGROUND

[redacted], 2019, the Health Insurance Exchange Access Health CT ("AHCT") issued a Notice of Action ("NOA") to [redacted], (the "Appellant") granting Medicaid Husky B- Band 2 coverage, effective [redacted] 2019, for [redacted] (the "child") and denying Medicaid Husky A for the Appellant and the child.

[redacted] 2019, the Appellant requested a hearing to contest the denial of Medicaid HUSKY A.

[redacted], 2019, the Office of Legal Counsel, Regulations, and Administrative Hearings (the "OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2019.

[redacted], 2019, 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 § 457.113, OLCRAH held an administrative hearing by telephone. The following individuals participated in the hearing:

[redacted], Appellant
Sabrina Solis, AHCT Representative
Veronica King, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly denied Medicaid HUSKY A coverage for the Appellant and her child.

FINDINGS OF FACT

1. The Appellant's child was active on the Medicaid/HUSKY A program under the Transitional Medical Assistance program ("TMA") from [redacted] 2018, through [redacted] 2019. (Exhibit 2: Eligibility Determination screen, Exhibit 4: Enrollment Details screen print and Hearing Record)

2. [redacted], 2019, AHCT received a change report application information [redacted]. (Exhibit 1: Application [redacted]/19 and Hearing Record)

3. The Appellant requested coverage for herself and her child. She reported that she files taxes as single, never married and claims her minor child as tax dependent. AHCT determined that the Appellant and her child have a household of two (2). (Exhibit 1 and Hearing Record)

4. The Appellant self-declared gross monthly income of $4,414.33 for herself. (Exhibit 1 and Hearing Record)

5. AHCT received two (2) pay subs from the Appellant. The pay stubs shows the Appellant is pay biweekly [redacted]/19 gross pay $2,057.08 and [redacted]/19 gross pay $2,074.66. (Exhibit 5: Pay Stubs and Hearing Record)

6. AHCT did not use the provided pay stubs because would not change the Appellant's eligibility. AHCT's representative manually calculated the Appellant's monthly MAGI income as following, [redacted]/18 $2,057.08 + [redacted]/19 $2,074.66= $4,131.74/2 = $2,065.87 *2.15= $4,441.62. (Exhibit 5 and AHCT's Representative's Testimony)

7. AHCT determined the Appellant and her child did not qualify for Medicaid HUSKY A as a household of two because they did not meet the Medicaid Husky A financial criteria. The Appellant's minor child qualified for Husky B- Band 2. (Exhibit 2)

8. [redacted], 2019, AHCT sent the Appellant a Notice of Action granting Husky B- Band 2 for the minor child, effective [redacted] 2019. The letter further stated that the Appellant do not qualify for Husky A – Parents & Caretakers because she is in a household with $4,414.00 of monthly income. (Exhibit 5: Notice of Action, [redacted]/19)

9. The Federal Poverty Limit ("FPL") for a household of two equaled $1,372.00 per month effective March 1, 2018. (Federal Register)
10. The issuance of this decision is timely under Connecticut General Statutes 17b-61(a), which requires that a decision be issued within 90 days of the request for an administrative hearing. The Appellant requested an administrative hearing on [redacted] 2019. This decision, therefore, was due no later than [redacted] 2019. (Hearing Record)

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statutes ("Conn. Gen. Stat.") 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 Conn. Gen. Stat. 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 ("C.F.R") § 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 C.F.R § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

5. 45 C.F.R § 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. 42 C.F.R 435.603(f)(1)(2)(iii)(3)(iii) provides for the construction of the modified adjusted gross income ("MAGI") household.

7. 42 C.F.R § 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 expensed are excluded from income.
   (3) American Indian/Alaska Native exceptions.

8. Title 26 of the United States Code ("U.S.C") provides for 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.

9. 26 U.S.C § 262(a) provides that except as otherwise expressly provided in this chapter, no deduction shall be allowed for personal, living or family expenses.

10. 42 C.F.R §435.603(d) 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, 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.

11. AHCT correctly determined that the Appellant and her child have a MAGI household of two (2) people.

12. Five percent of the FPL for a family of two (2) is $68.60 ($1,372.00 * .05) per month.

13. AHCT correctly determined that the Appellant's household reported income at the time of determination was $ 4,414.33 per month.

14. AHCT correctly determined that the Appellant's household's countable MAGI for a household of two based on the reported income at time of application was $4,345.73 ($4,414.33 - $68.60) per month.

15. Title 42 C.F.R § 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.

16. Title 42 C.F.R § 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.

17. 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.

18. One hundred fifty percent of the FPL for a household of two (2) is $2,058.00 ($1,372.00 * 1.50) per month.

19. One hundred ninety-six per cent of the FPL for a household of two (2) is $ 2,689.12($1,372.00 * 1.96) per month.

20. The Appellant's countable MAGI household income of $4,345.73 per month exceeds the income threshold for Medicaid/Husky A for Parents and Caretakers for a household of two, $2,058.00.

21. The Appellant's countable MAGI household income of $4,345.73 per month exceeds the income threshold for Medicaid/Husky A for Children for a household of two, $2,689.12.

22. AHCT correctly determined that the Appellant is over income for Medicaid/HUSKY A for Parents and Caretakers medical insurance.

23. AHCT correctly determined that the Appellant's child is over income for Medicaid/HUSKY A for Children medical insurance.

24. Public Act 15-5 June Sp. Session, Section 371(a) provides The Commissioner of Social Services shall review whether a parent or needy caretaker relative, who qualifies for Medicaid coverage under Section 1931 of the Social Security Act and is no longer eligible on and after August 1, 2015, pursuant to section 17b-261 of the general statutes, as amended by this act, remains eligible for Medicaid under the same or a different category of coverage before terminating coverage.

25. Uniform Policy Manual ("UPM") § 2540.09 (A) (1) provides that the group of people who qualify for Extended Medical Assistance includes members of assistance units who lose eligibility for HUSKY A for Families ("F07") (cross reference: 2540.24) under the following circumstances:

> the assistance unit becomes ineligible because of hours of, or income from, employment; or the assistance unit was discontinued, wholly or partly, due to new or increased child support income.

26. UPM § 2540.09 (B) provides for the duration of eligibility.

(1) Individuals qualify for HUSKY A under this coverage group for the twelve month period beginning with the first month of ineligibility for HUSKY A (F07).

(2) If ineligibility for HUSKY A for Families (F07) occurs prior to the termination of assistance, the Extended Medical Assistance period begins with the first month that the family was not eligible for HUSKY A for Families (F07).

27. AHCT correctly determined the Appellant's child became eligible for TMA effective [redacted] 2018 and ended on [redacted], 2019, which was twelve months after eligibility for the Medicaid/HUSKY A (F07) ended.

28. AHCT correctly determined that eligibility for the TMA ended on [redacted], 2019, which was twelve months after eligibility for the Medicaid/HUSKY A (F07) ended.

29. AHCT correctly denied Medicaid/HUSKY A for all household members as the countable MAGI household income exceeds the income limit.

DISCUSSION

Medicaid Husky A eligibility is based on Modified Adjusted Gross Income. Based on the income reported by the Appellant at time of application, all members of the household are over income and therefore not eligible for the Medicaid Husky A Program.

At hearing time, the Appellant testified that her child was receiving extensive orthodontist treatment and she would like to keep the Husky A coverage until end of the treatment. Unfortunately, the Affordable Care Act and its supporting regulation is clear in regards to the MAGI countable income and does not allow for exceptions due to medical need.

[redacted], 2019, the Department correctly determined the Appellant's applicable MAGI household and correctly denied the Appellant's application for Medicaid Husky A for the Appellant and her child.

DECISION

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

Veronica King
Hearing Officer

Cc: Beck Brown, Health Insurance Exchange Access Health CT
Mike Towers, Health Insurance Exchange Access Health CT
Sabrina Solis, 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.