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

Client ID # [redacted]
Hearing Request # 136975

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2019, the Health Insurance Exchange Access Health CT ("AHCT") sent [redacted], ("the Appellant") a Notice of Action discontinuing her Medicaid/Husky D healthcare coverage.

On [redacted], 2019, the Appellant requested a hearing to contest the discontinuance of such benefits.

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

On [redacted] 2019, in accordance with sections 17b-60, 17b-264, and 4-176e to 4-189, inclusive, of the Connecticut General Statues, 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 were present at the hearing:

[redacted], Appellant
Debra Henry, Health Insurance Exchange, Access Health CT Representative
Shelley Starr, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the Appellant's Medicaid/Husky D healthcare insurance.

FINDINGS OF FACT

1. On [redacted] 2019, the Appellant began full time employment at [redacted] earning $21.00 per hour. (Appellant's Testimony; Hearing Record)

2. On [redacted], 2019, the Appellant submitted a change reporting application through the Access Health; Health Insurance Exchange. (Hearing Summary; Exhibit 4: Application [redacted])

3. On the change application, the Appellant reported total monthly income of $3,434.79 and $0.00 deductions. (Hearing Summary; Exhibit 4: Application [redacted])

4. The Appellant resides in a household consisting of one member, who does not file taxes. (Hearing Summary; Exhibit 4: Application [redacted])

5. The Federal Poverty Limit ("FPL") for a household of one at the time of the change was $12,490.00 per year which converted equals $1,040.83. (12,490.00 / 12 = $1,040.83. (Department's Testimony; Exhibit 5: Notice dated [redacted], 2019; Federal Register)

6. The FPL for Husky D Medicaid for adults between 19 and 64 years of age in a household of one is $1,396.56 (138% of the FPL). Effective [redacted], 2019, the FPL increased to $1,436.00. (Hearing Summary; Department's Testimony)

7. AHCT determined the Appellant did not qualify for Medicaid/Husky D coverage as a household of one because the household monthly income was over the allowable limit. (Hearing Summary; Department's Testimony; Exhibit 5: Notice dated [redacted] 2019)

8. On [redacted] 2019, AHCT sent the Appellant a notice advising ; We updated your Health Care Application, discontinuing HUSKY D Medicaid. The notice stated the reason for the discontinuance is "you are in a household of $3,435.00 of monthly income. The income limit for a household size of 1 is $1,436.00." (Exhibit. 5: We Updated your Health Care Application Notice dated [redacted], 2019; Department's Testimony)

9. The Appellant is eligible to purchase qualified health insurance and enrolled in the Connect care Bronze plan for the month of [redacted] 2019, as her employer provides [redacted] insurance effective [redacted] 2019. (Appellant's Testimony; Hearing Record.)

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 is due not later than [redacted], 2019, and is therefore timely. (Hearing Record)

CONCLUSIONS OF LAW

1. Section17b-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. Section17b-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. 42 CRF § 431.245 provides for notifying the applicant or beneficiary of a State agency decision; The agency must notify the applicant or beneficiary in writing of (a) The decision; and (b) His right to request a State agency hearing or seek judicial review, to the extent that either is available to him.

   On [redacted] 2019, the AHCT notified the Appellant in writing of the proposed Husky Health coverage discontinuance and [redacted] rights to a Hearing/Appeal.

7. Title 42 CFR § 431.211 provides for advance notice; The State or local agency must send a notice at least 10 days before the date of action, except as permitted under §§431.213 and 431.214.

   UPM § 1570.10 (A)(1) provides for Notice requirements; Except in situations described below, the Department mails or gives adequate notice at least ten days prior to the date of the intended action if the Department intends to discontinue, terminate, suspend or reduce benefits.

   On [redacted], 2019, the AHCT issued notice to the Appellant ten days prior to the [redacted], 2019 Medicaid/Husky D discontinuance.

8. 42 CFR § 435.603(d)(1) provides for the construction of the modified adjusted gross income ("MAGI") household. *Household income*—(1) *General rule*. 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.

   The AHCT correctly determined the Appellant is a MAGI household consisting of one person.

9. 42 CFR §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.(4) 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.

Five percent of the FPL for a family of one is $624.50 ($12,490.00 x .05) per year which was converted to $52.04 ($624.50 /12 months) per month.

The Appellant's household's countable MAGI for a household of one based on the reported income at time of change was $3,382.75 (3,434.79 – $52.04 per month).

10. 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.

One Hundred thirty-three percent of the FPL for a household of one is $1,384.30 ($1,040.83 x 1.33).

The Appellant's countable MAGI household income of $3,382.75 per month exceeds the income threshold for one of $1,384.30.

The Appellant is over income for Medicaid/Husky D medical insurance.

AHCT was correct to discontinue the Appellant's Medicaid Husky D effective [redacted] 2019, because [redacted] monthly income exceeded the Husky D income limit for a household of one.

DISCUSSION

Husky D Medicaid eligibility is based on Modified Adjusted Gross Income. Based on the new income reported by the Appellant at the time of the change, the Appellant is over income and therefore not eligible for the Husky D program. The Department issued proper notice to the Appellant of the determination results and proposed discontinuance in accordance to the parameters established in regulation.

DECISION

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

Shelley Starr
Hearing Officer

Pc: Becky Brown, Health Insurance Exchange, Access Health CT
Mike Towers, Health Insurance Exchange, Access Health CT
Debra Henry, 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.