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

[redacted], 2019
Signature Confirmation

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

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2019, the Health Insurance Exchange Access Health CT ("AHCT") issued a notice of action ("NOA") to [redacted] (the "Appellant") explaining that her grandson, [redacted] (her "Grandson"), would lose his HUSKY D health coverage because he was in a household with income that exceeded the income limit for the program.

On [redacted], 2019, the Appellant requested a hearing to appeal her Grandson's loss of HUSKY D medical 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 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 were present at the hearing:

[redacted], Appellant
Krystal Sherman-Davis, AHCT Representative
James Hinckley, Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether AHCT correctly discontinued the Appellant's Grandson's HUSKY D Medicaid because his household's income exceeded the limit.

FINDINGS OF FACT

1. The Appellant is 61 years old. She is the primary applicant for healthcare coverage for herself, for her Grandson, and for another grandchild who lives with her. (Hearing Record)

2. The Appellant's Grandson is 19 years old. He was eligible and enrolled in HUSKY D from [redacted] 2018 to [redacted] 2019. (Hearing Record)

3. On [redacted] 2019, the Appellant filed a HUSKY Health renewal form with AHCT. (Hearing Record)

4. The renewal form reported that the Appellant currently has no source of income, and that she does not plan to file taxes in 2019, nor does she expect to be a tax dependent of any other individual. (Ex. 3: Application Information)

5. The renewal form reported that the Appellant's Grandson is currently employed and expects annual income of $19,702.56 in 2019, and that he expects to file taxes for tax year 2019 as single with no dependents. (Ex. 3)

6. On [redacted], 2019, AHCT sent an NOA to the Appellant explaining that her Grandson would lose his HUSKY D coverage as of [redacted], 2019, because his household had monthly income of $1,642.00 and the income limit for a household of 1 is $1,436.00. (Ex. 1: *Here are the Results of your Health Care Renewal* notice dated [redacted] 2019)

7. The Appellant's Grandson has been paying household bills on behalf of the Appellant, because he has income and she currently does not. (Appellant's testimony)

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. Conn. Gen. Stat. Sec. 17b-264 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 health insurance markets and in benefit 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. 45 CFR § 155.300(b) *Medicaid and CHIP* In general, references to Medicaid and CHIP regulations in this subpart refer to those regulations as implemented in accordance with rules and procedures which are the same as those applied by the State Medicaid or State CHIP agency or approved by such agency in the agreement described in § 155.345(a).

7. 45 CFR § 155.305(c) *Eligibility for Medicaid* The Exchange must determine an applicant eligible for Medicaid if he or she meets the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI-based income, as certified by the Medicaid agency in accordance with 42 CFR 435.1200(b)(2), has a household income, as defined in 42 CFR 435.603(d), that is at or below the applicable Medicaid MAGI-based income standard as defined in 42 CFR 435.911(b)(1) and –

(1) Is a pregnant woman, as defined in the Medicaid State Plan in accordance with 42 CFR 435.4;
(2) Is under age 19;
(3) Is a parent or caretaker relative of a dependent child, as defined in the Medicaid State plan in accordance with 42 CFR 435.4; or
(4) Is not described in paragraph (c)(1), (2), or (3) of this section, is under age 65 and is not entitled to or enrolled for benefits under Part A of title XVIII of the Social Security Act, or enrolled for benefits under Part B of title XVIII of the Social Security Act.

8. The Appellant's Grandson is in the category of individuals described in 45 CFR 155.305(c)(4). His eligibility for Medicaid is determined by the Exchange based on MAGI-based income rules.

9. 42 CFR § 435.119(b) provides as follows:

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.

10. "Household income -- (1) General rule. Except as provided in paragraphs (d)(2) and (d)(3) 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(d)

11. 42 CFR § 435.603(d)(4) provides as follows:

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.

12. 42 CFR § 435.603(f) provides as follows:

Household – (1) 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 or 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 whom such individual *expects* to claim as a tax dependent. (emphasis added)
….

13. The Appellant's Grandson comprised a household of one person. The Appellant declared on the renewal form that her Grandson expected to file a tax return for tax year 2019 as single, and expected to claim no tax dependents.

14. 133 percent of the federal poverty level for a household of one person as of [redacted], 2019 was $1,384.31 monthly. *Federal Register* / *Vol. 84*, *No. 22* / *Friday, February 1, 2019* / *pp. 1167-1168*

15. 100 percent of the federal poverty level for a household of one person as of [redacted], 2019 was $1,040.83 monthly, and 5 percent of that figure was $52.04. *Federal Register* / *Vol. 84*, *No. 22* / *Friday, February 1, 2019* / *pp. 1167-1168*

16. The Appellant's Grandson's declared monthly income of $1,641.88 (his declared annual income, converted to a monthly figure), reduced by 5 percentage points of the FPL for a household of one person ($52.04), was $1,589.84.

17. The Appellant's Grandson did not meet the income eligibility criteria for HUSKY D. His household's monthly income after subtraction of 5% of the FPL for his household size ($1,589.84) exceeded the income standard of 133% of the FPL for his household size ($1,384.31).

18. AHCT correctly discontinued the Appellant's Grandson's HUSKY D Medicaid effective [redacted], 2019, because his household's income exceeded the income limit for the program.

19. The figures in AHCT's NOA differ from the figures in the Conclusions of Law above, but are not erroneous. Instead of subtracting 5% of the FPL from the counted income, AHCT added the 5% to the income standard and compared the Grandson's total income to the increased standard.

20. "Financial eligibility for Medicaid for applicants, and other individuals not receiving Medicaid benefits at the point at which eligibility for Medicaid is being determined, must be based on current monthly household income and family size."
42 CFR § 435.603(h)(1)

21. **The Appellant's Grandson was correctly discontinued from HUSKY D, but is not precluded from reapplying for the program at any time. Eligibility for the coverage is always based on *current* information, so if his income has decreased, or he did not estimate it correctly, or his expected tax filing status has changed, a new application may result in a different eligibility decision.**

DISCUSSION

The Appellant questioned why her Grandson was considered to be a household of one person despite currently supporting three individuals. Household composition is based on *expected* tax filing status, as declared by the individual. The Exchange cannot offer tax-related advice, such as whether the Grandson could be entitled to claim tax dependents. His household size was correctly determined based on his declared intention to file as single with no dependents. If his expected tax filing status changes, he may declare the change on a new application for benefits.

DECISION

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

James Hinckley
Hearing Officer

cc: Becky Brown
Mike Towers
Krystal Sherman-Davis

Advanced Premium Tax Credits (APTC) or Cost Sharing Reduction (CSR)
Right to Appeal

For APTC or CSR eligibility determinations, the Appellant has the right to appeal to the United States Department of Health and Human Services (HHS) within 30 days of the date of this decision. To obtain an Appeal Request Form, go to https://www.healthcare.gov/can-i-appeal-a- marketplace-decision/ or call 1-800-318-2596 (TTY: 1-855-889-4325). HHS will let the Appellant know what it decides within 90 days of the appeal request. There is no right to judicial review of the decision by HHS.

There is no right to request reconsideration for denials or reductions APTC or CSR.

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.

There is no right to request reconsideration for denials or reductions of APTC or CSR.

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 extension is 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.