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

Case: [redacted]
Client: [redacted]
Request: [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2019 Connecticut's Health Insurance Exchange/Access Health CT ("AHCT"), issued [redacted] the "Appellant") a notice discontinuing his HUSKY D/Medicaid coverage effective [redacted] 2019 for the reason that his monthly income exceeded the program's limits for an individual.

On [redacted] 2019 and again on [redacted] 2019, the Appellant filed an administrative hearing request with the Office of Legal Counsel, Regulations and Administrative Hearings ("OLCRAH").

On [redacted] 2019, the 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 ("C.F.R.") §§ 155.505 (b) and 155.510 and/or 42 C.F.R. § 457.113, OLCRAH held an administrative hearing by telephone. The following individuals participated:

[redacted] Appellant
[redacted] Appellant's witness (brother)
Krystal Sherman-Davis, AHCT's representative
Eva Tar, Hearing Officer

The administrative hearing record closed [redacted] 2019.

STATEMENT OF ISSUE

The issue to be decided is whether AHCT correctly determined that the Appellant's monthly income rendered him ineligible for HUSKY D/Medicaid coverage.

FINDINGS OF FACT

1. The Appellant's date of birth is [redacted] (Appellant's testimony)

2. On or before [redacted] 2018, the Appellant's brother began contributing between $1,400.00 and $2,000.00 per month to the Appellant for his support. (Appellant's witness's testimony)

3. The Appellant's brother's contributions are the Appellant's sole source of income. (Appellant's testimony)

4. The Appellant did not file income taxes for the 2018 tax year. (Appellant's testimony)

5. The Appellant's brother did not claim the Appellant as a dependent on the brother's income taxes for the 2018 tax year. (Appellant's witness's testimony)

6. In [redacted] 2019, the Appellant was a HUSKY D/Medicaid recipient. (AHCT's Exhibit B)

7. In [redacted] 2019, the Appellant received $2,000.00 from his brother. (AHCT's Exhibit C)

8. On [redacted] 2019, AHCT terminated the Appellant's HUSKY D/Medicaid coverage effective [redacted] 2019; AHCT noted that the Appellant was qualified to purchase health insurance under a Qualified Health Plan for 2019 with premium tax credits and cost sharing benefits. (AHCT's Exhibit B)

9. Connecticut General Statutes § 17b-61 (a) provides that a final decision be issued within 90 days of a request for an administrative hearing. On [redacted] 2019, the OLCRAH received the Appellant's hearing request. This final decision is not due until [redacted] 2019. This decision therefore is timely.

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes provides in part that the Department of Social Services is designated as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

   Section 17b-260 of the Connecticut General Statutes provides in part 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.

Title 45, Code of Federal Regulations ("C.F.R."), section 155.110 (a) provides:

> 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.

2. "For coverage dates on or after January 1, 2014, the department shall use the modified adjusted gross income financial eligibility rules set forth in Section 1902 (e)(14) of the Social Security Act and the implementing regulations to determine eligibility for HUSKY A, HUSKY B and HUSKY D applicants, as defined in section 17b-290…." Conn. Gen. Stat. § 17b-261 (a).

   "HUSKY D" or "Medicaid Coverage for the Lowest Income Populations program" means Medicaid provided to non-pregnant low-income adults who are age eighteen to sixty-four, as authorized pursuant to section 17b-8a. Conn. Gen. Stat. 17b-290 (16).

   "The commissioner shall make periodic investigations to determine eligibility and may, at any time, modify, suspend or discontinue an award previously made when such action is necessary to carry out the provisions of the … medical assistance program…." Conn. Gen. Stat. § 17b-80.

   The Appellant is a non-pregnant adult between the ages of [redacted] years and [redacted] years.

   The AHCT acted within its authority to review the Appellant's HUSKY D/Medicaid case to determine whether he continued to meet the eligibility requirements of the HUSKY D/Medicaid program.

3. "**Application of modified adjusted gross income (MAGI).** (a) *Basis, scope, and implementation.* (1) This section implements section 1902 (e)(14) of the Act. (2) 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, …." 42 C.F.R. § 435.603 (a)(1) and (a)(2).

"Basic rule. 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." 42 C.F.R. § 435.603 (c).

"*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." 42 C.F.R. § 435.603 (d)(1).

The AHCT correctly determined as a HUSKY D/Medicaid program recipient, the Appellant is subject to application of the MAGI standard for an individual with respect to determining his eligibility for that program.

4. Title 26 of the U.S. Code ("U.S.C."), section 62 defines the term "adjusted gross income."

> **Modified adjusted gross income.** 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. 26 U.S.C. § 36B (d)(2)(B).

"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…." 42 C.F.R. § 435.603 (e)(1).

5. *"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 remainder of the current calendar year." 42 C.F.R. § 435.603 (h)(2).

> In determining current monthly or projected annual household income and family size under paragraphs (h)(1) or (h)(2) of this section, the agency may adopt a reasonable method to include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income. Such future increase or decrease in income or family size must be verified in the same manner as other income and eligibility factors, in accordance with the income and

eligibility verification requirements at §435.940 through §435.965, including by self-attestation if reasonably compatible with other electronic data obtained by the agency in accordance with such sections. 42 C.F.R. § 435.603 (h)(3).

AHCT correctly determined that the Appellant's monthly income equaled $2,000.00 per month when it accepted his [redacted] 2019 self-attestation to the Department of Social Services.

8. "*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." 42 C.F.R. § 435.119 (b).

42 C.F.R. § 435.603 (d)(4) provides:

> 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.

In 2019, the federal poverty level for a household of one living in Connecticut was $12,490.00 per year.[1]

In [redacted] 2019, the Appellant's monthly income of $2,000.00 exceeded $1,436.00 per month, or 138% of the (monthly) federal poverty level for an individual.

AHCT correctly determined that the Appellant's monthly income rendered him ineligible for HUSKY D/Medicaid coverage.

DISCUSSION

The Appellant argues that the monthly contributions he receives from his brother should not be considered in determining his eligibility for the HUSKY D/Medicaid program. The Appellant cites to IRS guidelines as to when a donor must pay an additional gift tax.

While a number of federal regulations governing the HUSKY D/Medicaid program refer to U.S. tax code, some depart from U.S. tax code when it comes to determination of modified adjusted gross income ("MAGI").

[1] U.S. Department of Health & Human Services website: https://aspe.hhs.gov/2019-poverty-guidelines.

Of particular concern, Title 42 of the Code of Federal Regulations ("C.F.R."), section 435.603 does not define "gifts" or identify "contributions from family members."

However, 42 C.F.R. § 435.603 (e)(1) provides insight, stating in part:

> *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]

It is reasonable to conclude that for the purposes of the HUSKY D/Medicaid program a monthly contribution from a relative to a HUSKY D/Medicaid recipient is a "lump sum." Therefore, the Appellant's receipt of regular monthly contributions from his brother is income for the purposes of this welfare program.

DECISION

The Appellant's appeal is DENIED.

Eva Tar – electronic signature
Eva Tar
Hearing Officer

cc: Krystal Sherman-Davis, AHCT
Becky Brown, AHCT
Mike Towers, AHCT

[2] Emphasis added.

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.