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

, 2019
Signature Confirmation

Application #
Client ID
Hearing Request # 133687

NOTICE OF DECISION

PARTY

PROCEDURAL BACKGROUND

On , 2019, the Health Insurance Exchange Access Health CT ("AHCT") sent , ("The Appellant") a Notice of Action ("NOA") denying Medicaid/Husky D healthcare coverage for exceeding the income limit.

On 2019, The Appellant requested a hearing to contest the denial of Medicaid/Husky D benefits.

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

On , 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:

, Appellant
Sabrina Solis, AHCT Representative

Swati Sehgal, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly denied the Medicaid/Husky D healthcare insurance.

FINDINGS OF FACT

1. The Appellant was an active recipient of HUSKY D/Medicaid through AHCT. (Hearing Record)

2. The Appellant is a single individual with no dependents. The Appellant is a household of one. (Exhibit 4: Application , Appellant's testimony)

3. On 2019, the Appellant submitted copies of his pay stubs from and . The Appellant provided pay stubs for the week of /19 for $71.03, week of /19 for $40.53, week of /19 for $64.34 and week of /19 for $65.80. There were pay stubs missing for the week of /19, /19 and /19. The Appellant did not get paid for the week of /19 and /19. Missing pay stub for week of /19 was calculated by subtracting year to date for week of /19 + gross income for week of 2/19 from year to date for week of /19 ($1256.96 year to date for week of /19 + $65.80 for week of /19= $1322.70 - $1430.34 year to date for week of /19= $107.64 for week of /19). (Exhibit 5)

4. On 2019, AHCT calculated the Appellant's gross income as $1466.74 per month. (Exhibit 4, Hearing Summary)

5. On , 2019, AHCT completed a change reported by the Appellant and updated the Appellant's countable monthly income on the healthcare application based on wage stubs he had provided. (Exhibit 4, Hearing Summary, Exhibit 5: Wage Stubs).

6. The Appellant's monthly income from is $214.55 ($71.03 + $40.53 +$0.00+ $0.00 + $64.34 + $107.64 + $65.80 = $349.28/7 = $49.90 x 4.3) (Exhibit 5)

7. The Appellant's gross monthly income from . is $1245.93(564.25+594.76=1159.01/2=579.50x2.15) (Exhibit 5)

8. The Appellant's total gross monthly income is $1460.49 ($214.55; $1245.93;). (Hearing record)

9. The Appellant did not report any allowable income deductions. (Exhibit 4, Appellant's testimony)

10. On [redacted] 2019, AHCT sent a letter to the Appellant denying HUSKY D Medicaid for exceeding the income limit for a household of one. (Exhibit 1: Notice of Action, [redacted]/19)

11. The Federal Poverty Limit ("FPL") for a family of one at the time of change was $12,490.00 per year which converted equals $1040.83 ($12,490 / 12 = $1040.83) per month. (Federal Register).

12. The issuance of this decision is timely under section 17b-61(a) of Connecticut General Statutes, 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, and is therefore timely. (Hearing Record)

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. 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.

7. The Appellant is single and has no tax dependent. AHCT correctly determined he is MAGI household of one.

8. 42 CFR § 435.603(e) provides in part 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

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. 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.

10. Five percent of the FPL for a family of one is $823.00 ($12,490.00 x .05) per year which was converted to $52.42 ($624.50/12) per month.

11. The Appellant's household's countable MAGI for a household of one based on the reported income at the time of application was $1408.07 ($1460.49 - $52.42) per month.

12. 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.

13. One Hundred thirty-three percent of the FPL for a household of one is $1384.30 ($1040.83 x 1.33).

14. The Appellant's household's countable MAGI household income of $1408.07 per month exceeds the income threshold for one, $1384.30.

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

16. The Department was correct to deny HUSKY D/Medicaid for the Appellant's household.

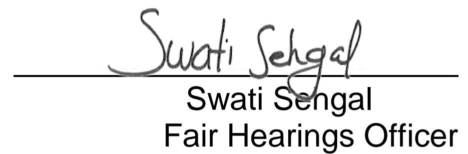
DISCUSSION

HUSKY D Medicaid eligibility is based on Modified Adjusted Gross Income. Based on the income reported by the Appellant at the time of the application the Appellant is over income and therefore not eligible for the HUSKY D program. The Appellant's wage stubs from [redacted] and [redacted] reflect the total monthly gross income

of $1460.49. AHCT inaccurately calculated the Appellant's monthly gross income as $1466.74 which is slightly higher than his actual monthly gross income. However, it does not impact the eligibility of HUSKY D as the Appellant is over the income limit with his income of $1460.49.

DECISION

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



Swati Sengal
Fair Hearings Officer

CC: Sabrina Solis, Becky Brown, Mike Towers, Conduent

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 a 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.