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

[redacted] **2019**
Signature Confirmation

Case ID # [redacted]
Client ID # [redacted]
Request # 143849

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 his Medicaid/Husky D assistance.

On [redacted] 2019, the Appellant requested an administrative hearing to contest AHCT's decision to discontinue such benefits.

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

[redacted] in accordance with sections 17b-60, 17b-264 and 4-176e to 4-184, inclusive, of the Connecticut General Statutes, 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 called in for the hearing:

[redacted] Appellant
Krystal Sherman-Davis, AHCT Representative
Christopher Turner, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly discontinued the Appellant's healthcare coverage under the Medicaid/Husky D program due to the Appellant's income in excess of the program limit.

FINDINGS OF FACT

1. [redacted] 2019, the Appellant submitted a Medicaid/Husky D change application form by telephone with self-declared monthly-earned income from two jobs. (Exhibit 5: Application form; Hearing summary; Appellant's testimony)

2. [redacted] 2019, AHCT issued the Appellant a notice of action. The notice indicated the Appellant is not eligible for the Medicaid/Husky D program because his income of $1,594.00 exceeds the income limit of $1,436.00. (Exhibit 3: Notice)

3. The Appellant is [redacted] years old ([redacted]), files taxes as a single individual with no dependents and is deemed the primary applicant. (Exhibit 5)

4. The Appellant works for [redacted] and is a self-employed [redacted] driver. The Appellant self-declared $270.00 weekly ($1,161.00 monthly) for [redacted] and $5,200 yearly for [redacted] ($433.33 monthly) equals $1,594.33 monthly. (Exhibit 5; Appellant's testimony)

5. The Federal Poverty Level ("FPL") for a household of one used in the calculation of the Appellant's eligibility was $1,041.00. (Hearing summary; Record)

6. AHCT added five percent (5%) to the FPL income standard when determining the Appellant's eligibility. (Record)

7. 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], and a decision was due by [redacted] 2019. (Hearing Record)

CONCLUSIONS OF LAW

1. Connecticut General Statutes ("Conn. Gen. Stat.") § 17b-2 provides the Department of Social Services is designated as the state agency for the administration of (6) the Medicaid program pursuant to Title XIX of the Social Security Act.

   Conn. Gen. Stat. § 17b-260 provides 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. § 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. Conn. Gen. Stat. § 17b-290 (16) provides "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.

   Title 42 of the Code of Federal Regulations ("C.F.R.") § 435.119 (b) provides that 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.

   AHCT correctly determined the Appellant is a non-pregnant adult age 19 or older and under age 65.

4. 42 C.F.R. § 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.

   42 C.F.R. § 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) The right to request a State agency hearing or seek judicial review, to the extent that either is available to him/her.

   AHCT properly notified the Appellant in writing on [redacted] 2019 of his proposed Husky Health discontinuance effective [redacted] 2019 and his rights to a Hearing/Appeal.

5. 42 of the C.F.R. § 435.2 provides for purpose and applicability. This part sets forth, for the 50 states, the District of Columbia, the Northern Mariana Islands, and American Samoa – (a) The eligibility provisions that a State plan must contain; (b) The mandatory and optional groups of individual to whom Medicaid is provided under a State plan; (c) The eligibility requirements and procedures that the Medicaid agency must use in determining and redetermining eligibility, and requirements it may not use; (d) The availability of FFP for providing Medicaid and for administering the eligibility provisions of the plan; and (e) Other requirements concerning eligibility determinations, such as use of an institutionalized individual's income for the cost of care.

6. 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.

   45 C.F.R. § 155.505(c) provides that Exchange eligibility appeals may be conducted by - (1) 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.

   45 C.F.R. § 155.505(d) provides that an appeals process established under this subpart must comply with § 155.110(a).

   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.

7. 45 C.F.R. § 155.320(a)(1) provides that the Exchange must verify information in accordance with this section only for an applicant or tax filer who requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b). (2) Unless a request for modification is granted in accordance with § 155.315(h), the Exchange must verify or obtain information in accordance with this section before making an eligibility determination for insurance affordability programs, and must use such information in such determination.

45 C.F.R. § 155.320(c)(1)(i) provides for data verification of household income and household size. (A) For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number, the Exchange must request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social security benefits described in 26 CFR 1.36B-1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS. (B) If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed in accordance with section 6103(l)(21) of the Code and its accompanying regulations, the Exchange must proceed in accordance with § 155.315(f)(1).

45 C.F.R. § 155.320(c)(ii) provides for Data regarding MAGI-based income. For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B-1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), the Exchange must request data regarding MAGI-based income in accordance with 42 CFR 435.948(a).

45 C.F.R. § 155.320(c)(3)(ii) provides for the basic verification process for annual household income.

(A) The Exchange must compute annual household income for the family described in paragraph (c)(3)(i)(A) of this section based on the data described in paragraph (c)(1)(i) of this section;

(B) The Exchange must require the applicant to attest regarding a tax filer's projected annual household income;

(C) To the extent that the applicant's attestation indicates that the information described in paragraph (c)(3)(ii)(A) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the household income data in paragraph (c)(3)(ii)(A) of this section;

(D) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must require the applicant to attest to the tax filer's projected household income for the benefit year for which coverage is requested.

AHCT correctly used the Appellant's self-declared monthly income of $1,594.33 ($433.33 [redacted] + $1,161.00 [redacted]) in its eligibility determination.

8. 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.

   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 expenses are excluded from income.
   (3) American Indian/Alaska Native exceptions.

9. Title 26 of the United States Code § 36B(d)(2)(B) provides that the term "modified adjusted gross income" ("MAGI") 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 C.F.R. § 1.36B-1(e)(1) provides in general, household income is the sum of-
   (i) A taxpayer's modified adjusted gross income ("MAGI") (including the modified adjusted gross income of a child for whom an election under section 1(g)(7) is made for the taxable year);
   (ii) The aggregate modified adjusted gross income of all other individuals who-
   (A) Are included in the taxpayer's family under paragraph (d) of this section; and
   (B) Are required to file a return of tax imposed by section 1 for the taxable year.

   One Hundred thirty-three percent of the FPL for a one-person household equals $1,384.53 ($1,041.00 x 1.33).

   Five percent of the FPL for one person equals $52.05 ($1,041.00 x 0.05).

   The Appellant's applicable income limit for one totaled $1,436.00 ($1,384.53 + $50.25 (rounded down to the nearest dollar)) per month.

The Appellant's MAGI of $1,594.00 exceeds the $1,436.00 monthly income limit for a household of one.

AHCT correctly used the Appellant's self-declared monthly income of $1,594.00 in the determination of the Appellant's Husky D eligibility based on a household of one.

AHCT correctly discontinued the Appellant's Medicaid/Husky D assistance as the Appellant's MAGI of $1,594.00 exceeded the Medicaid/Husky D income limit of $1,436.00.

DECISION

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

Christopher Turner
Hearing Officer

Cc: Becky Brown, Health Insurance Exchange, Access Health CT
Mike Towers, Health Insurance Exchange, Access Health CT
Krystal Sherman-Davis, Health Insurance Exchange, Access Health CT

APTC/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 of Advanced Primary Tax Credits (APTC) or Cost Sharing Reduction (CSR).

MEDICAID AND 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, law, and 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.

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, if 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.