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 # 144900

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") denying eligibility for HUSKY D health coverage because his income exceeded the limit for the program.

On [redacted], 2019, the Appellant requested a hearing to appeal his eligibility for 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] The Appellant
Krystal Sherman-Davis, AHCT Representative
James Hinckley, Hearing Officer

STATEMENT OF THE ISSUE

The issue is whether AHCT correctly denied HUSKY D Medical coverage for the Appellant because his income exceeded the limit.

FINDINGS OF FACT

1. The Appellant is an unmarried 57 year old man. (Hearing Record)

2. As of [redacted] 2019, the Appellant was enrolled in *HUSKY D – Adult* health care coverage through AHCT, and his eligibility was due for annual review. As of that time, his eligibility was based on him having household monthly gross income of $0.00. (Hearing Summary, Ms. Sherman-Davis' testimony)

3. Several months earlier, on a date the Appellant cannot specifically recall, the Social Security Administration determined that he was disabled and eligible for a monthly Social Security benefit. (Appellant's testimony)

4. On [redacted] 2019, the Appellant reported his Social Security income to AHCT by filing a telephone change report. (Hearing Record)

5. The Appellant's monthly Social Security benefit is $1,549.00. AHCT records accurately reflected, as of [redacted] 2019, that the Appellant received $1,549.00 in monthly income from Social Security. (Appellant's testimony, Ex. 1: Application Information)

6. On [redacted] 2019, AHCT issued a NOA to the Appellant explaining that he did not qualify for *HUSKY D – Adult* because he was in a household with $1,549.00 in monthly income, which exceeded the income limit for a household size of 1 of $1,436.00. (Ex. 3: *We updated your Health Care Application* notice dated [redacted], 2019)

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 falls into the category of individuals described in 45 CFR 155.305(c)(4). Although the Appellant receives Social Security, he is not yet entitled to benefits under Medicare Part A or Part B, so 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. 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*

13. 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*

14. **The Appellant's gross monthly income from Social Security is $1,549.00. After subtracting an amount equal to 5 percentage points of the FPL for a household of one person ($52.04), his net income for HUSKY D eligibility is $1,496.96.**

15. **The income standard applicable to the Appellant's household is $1,384.31 (133% of the FPL for a household of one person). His net monthly income of $1,496.96 as of [redacted] 2019, exceeded the income standard.**

16. **The income and income limit amounts in the NOA sent to the Appellant by AHCT differ from the figures in the Conclusions of Law above, but are not erroneous. Instead of subtracting 5% of the FPL for a household of one person from the counted income, AHCT added the 5% figure to the income standard it used, and compared the Appellant's total income to the increased standard. The result of AHCT's income comparison was exactly the same as the result calculated here.**

17. **AHCT was correct when it denied *HUSKY D – Adult* medical coverage eligibility for the Appellant, because his income exceeded the limit for the program.**

DISCUSSION

Because the Appellant qualifies for Social Security but is not yet entitled to Medicare Part A or Part B, he could *potentially* qualify either for HUSKY D through AHCT, or HUSKY C through the Department of Social Services. Because of certain differences between the programs, for individuals who could potentially qualify for either, either program might be the more appropriate, depending on their circumstances.

In the Appellant's case, he *does not qualify for HUSKY D* because his income exceeds the limit. Because his income is from a fixed source (Social Security, as opposed to, say earnings), and not expected to ever decrease, he will most likely never qualify for HUSKY D again. ***He should seek eligibility for HUSKY C from the Department of Social Services***.

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.