STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
OFFICE OF LEGAL COUNSEL, REGULATIONS, AND ADMINISTRATIVE HEARINGS
55 FARMINGTON AVENUE
HARTFORD, CT 06106-5033

[redacted] **2024**
Signature Confirmation

[redacted]
Hearing Request # 231095

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, [redacted] (the "Appellant") contacted the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") by telephone and requested an Administrative Hearing to contest the Health Insurance Exchange, Access Health CT ("Access Health") denial of medical benefits for his daughter, [redacted] (the "Applicant").

On [redacted] 2024, Access Health sent the Appellant a Notice of Action ("NOA") denying his request for medical benefits for his daughter, (the "Applicant") under the Husky A and Husky B Children Medicaid coverage groups.

On [redacted] 2024, the OLCRAH issued a notice to [redacted], the Appellant's Spouse / the Applicant's mother ("Spouse") scheduling an Administrative Hearing for [redacted] 2024.

On [redacted] 2024, in accordance with sections 17b-60, 17-61 and 4-176e to 4-184 inclusive, of the Connecticut General Statutes, and 45 C.F.R. §§ 155.505 (b) and 155.510 the OLCRAH held an Administrative Hearing by telephone.

The following individuals participated in the hearing:

[redacted], Appellant
[redacted], Spouse
Debra Henry, Access Health Appeals Coordinator
Jessica Gulianello, Hearings Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether Access Health correctly denied medical benefits under Husky A Medicaid for the Applicant.

FINDINGS OF FACT

1. On [redacted] 2024, Access Health received an online application from the Appellant. The Appellant (DOB: [redacted]), reported his Spouse (DOB: [redacted]), and their daughter (DOB: [redacted]) as members of the same household. The Appellant requested medical coverage for their daughter as the only Applicant. (*Exhibit 2: Online Application ID* [redacted] *– filing date* [redacted] *2024)*

2. Access Health determined the household size to be three (3) individuals. (*Hearing Summary dated* [redacted] *202[4], Access Health Testimony)*

3. The Appellant's tax status is married filing together with his Spouse as the primary and the Applicant is claimed as a tax dependent of the household. (*Exhibit 2: Online Application ID 12158978 – filing date* [redacted] *2024, Appellant's Testimony)*

4. The Appellant reported his anticipated income for 2024 as $118,00.00 annually. (*Exhibit 2: Online Application ID* [redacted] *– filing date* [redacted] */2024)*

5. Access Health converted the Appellant's anticipated annual income to monthly income as follows: $118,000.00 divided (/) 12 months equals (=) $9,833.00. *(Exhibit 4: Hearing Summary dated* [redacted] */202[4], Access Health Testimony)*

6. The Appellant is a full-time salaried employee of [redacted] located in [redacted]. His weekly gross weekly wages are $2,276.00. *(Appellant's Testimony)*

7. The household has employer-sponsored private health insurance coverage that meets the minimum value standard. (*Exhibit 2: Online Application ID* [redacted] *– filing date* [redacted] *202[4], Hearing Record)*

8. The Appellant reported that he is responsible for paying a medical insurance premium of $102.00 per week. (*Exhibit 2: Online Application ID* [redacted] *– filing date* [redacted]*/202[4])*

9. The Appellant did not report any additional deductions on the above-noted application. (*Exhibit 2: Online Application ID* [redacted] *– filing date* [redacted]*/202[4], Hearing Record)*

10. The Appellant testified that he is responsible for additional pretax payroll deductions as follows:

Deduction Type:	Deduction Amount:	Frequency
[redacted]	$137.00	Weekly
[redacted]	$38.00	Weekly
[redacted]	$102.00	Weekly
[redacted]	$17.00	Weekly
[redacted]	$4.00	Weekly

(Appellant's Testimony)

11. The household had transitioned from private health insurance coverage with [redacted] (received from the Spouse's former employer) to private health insurance coverage with [redacted] (received from the Appellant's current employer) effective [redacted] of 2024 following the Spouses voluntary departure with her employer to care for the Applicant. (*Appellant's Testimony)*

12. The Applicant was diagnosed with [redacted] in utero, a genetic medical condition that can manifest in various forms and impact major organs in the body including the [redacted]. The Applicant is currently experiencing [redacted] that require costly prescription medication. The Applicant has frequent visits to the cardiologist, optometrist, neurologist, and her pediatrician that often involve complex diagnostic testing and procedures including Magnetic Resonance Imaging (MRI), Electroencephalography (EEG), and overnight hospital stays. *(Appellant's Testimony)*

13. The previously noted change in the household's private health insurance coverage resulted in a significant increase in costs associated with the Applicant's medical care. The average out-of-pocket costs for medications increased from $5.00 to $300.00 per month, and co-pays for doctor visits increased up to 50%. *(Appellant's Testimony)*

14. On [redacted] 2024, Access Health mailed the Appellant an Eligibility and Enrollment notice ("1301"). The 1301 advised the Appellant that the Applicant did not qualify for a Husky Health plan. The W1301 stated, "[The Applicant] does not qualify for Husky A – Children because she is in a household with $9,833.00 of monthly income. The income limit for a household size of 3 is $4,165.00." The W1301 further stated, "The [Applicant] does not qualify for Husky B – Band 1 because she has other credible health coverage." *(Exhibit 5: W1301: Eligibility and Enrollment Notice, Hearing Summary dated [redacted]202[4], Access Health Testimony)*

15. The Appellant disputed that Access Health did not take the Applicant's genetic medical condition and the out-of-pocket costs associated with the condition into consideration in its determination. *(Appellant's Testimony)*

16. The issuance of this decision is timely under Connecticut General Statutes (Conn. Gen. Stat.") 17b-61(a), which requires that a decision be rendered within 90 days of the request for an Administrative Hearing. The Appellant requested an Administrative Hearing on [redacted] 2024. This decision, therefore, was due no later than [redacted] 2024, and is therefore timely. *(Hearing Decision)*

CONCLUSIONS OF LAW

1. Connecticut General Statutes ("Conn. Gen. Stat.") § 17b-2(6) provides 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.

2. Conn. Gen. Stat § 17b-260 provides for the 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.

   The Department has the authority to administer and determine eligibility for the Medicaid program.

3. 45 Code of Federal Regulations ("C.F.R.") § 155.110(a) provides as follows: 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.

Access Health is the Department's designated state entity to administer the Health Insurance Exchange Program.

4. 45 C.F.R § 155.505(c)(1) provides as follows: 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.

5. 45 C.F.R § 155.505(d) provides as follows: An appeals process established under this subpart must comply with § 155.110(a).

6. 45 C.F.R § 155.110(a)(2) provides as follows: 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: the State Medicaid agency, or any other State agency that meets the qualification of paragraph (a)(1) of this section.

Access Health has the authority to participate in Administrative Hearings.

7. Conn. Gen. Stat § 17b-261(a) provides as follows: Medical assistance shall be provided for any otherwise eligible person (1) whose income, including any available support from legally liable relatives and the income of the person's spouse or dependent child, is not more than one hundred forty-three per cent, pending approval of a federal waiver applied for pursuant to subsection (e) of this section, of the benefit amount paid to a person with no income under the temporary family assistance program, and (2) if such person is an institutionalized individual as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3), and has not made an assignment or transfer or other disposition of property for less than fair market value for the purpose of establishing eligibility for benefits or assistance under this section.

8. Conn. Gen. Stat § 17b-261(b) provides as follows: For the purposes of the Medicaid program, the Commissioner of Social Services shall consider parental

income and resources as available to a child under eighteen years of age who is living with his or her parents and is blind or disabled for purposes of the Medicaid program, or to any other child under twenty-one years of age who is living with his or her parents.

9. 42 C.F.R § 435.118(b) provides as follows: The agency must provide Medicaid to children under age 19 whose household income is at or below the income standard established by the agency in its State plan, in accordance with paragraph (c) of this section.

10. 42 C.F.R § 435.118(c) provides as follows: Income standard. (1) The minimum income standard is the higher of— (i) 133 percent FPL for the applicable family size; or (ii) For infants under age 1, such higher income standard up to 185 percent FPL, if any, as the State had established as of December 19, 1989 for determining eligibility for infants, or, as of July 1, 1989 had authorizing legislation to do so. (2) The maximum income standard for each of the age groups of infants under age 1, children age 1 through age 5, and children age 6 through age 18 is the higher of— (i) 133 percent FPL; (ii) The highest effective income level for each age group in effect under the Medicaid State plan for coverage under the applicable sections of the Act listed at paragraph (a) of this section or waiver of the State plan covering such age group as of March 23, 2010 or December 31, 2013, if higher, converted to a MAGI-equivalent standard in accordance with guidance issued by the Secretary under section 1902(e)(14)(A) and (E) of the Act; or (iii) For infants under age 1, 185 percent FPL.

11. 42 C.F.R § 435.4 provides as follows: Definition and use of term: Applicable modified adjusted gross income (MAGI) standard has the meaning provided in § 435.911(b)(1) of this part.

12. 42 C.F.R § 435.911(b)(1)(iii) provides as follows: Except as provided in paragraph (b)(2) of this section, applicable modified adjusted gross income standard means 133 percent of the Federal poverty level or, if higher – In the case of individuals under age 19, the income standard established in accordance with § 435.118(c) of this part;

13. 42 C.F.R § 435.603 provides the following: 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, except for individuals identified in paragraph (j) of this section and as provided in paragraph (a)(3) of this section. (3) In the case of determining ongoing eligibility for beneficiaries determined eligible

for Medicaid coverage to begin on or before December 31, 2013, application of the financial methodologies set forth in this section will not be applied until March 31, 2014 or the next regularly-scheduled renewal of eligibility for such individual under § 435.916 of this part, whichever is later. (b) Definitions. For purposes of this section - Child means a natural or biological, adopted or step child. Code means the Internal Revenue Code. Family size means the number of persons counted as members of an individual's household. In the case of determining the family size of a pregnant woman, the pregnant woman is counted as herself plus the number of children she is expected to deliver. In the case of determining the family size of other individuals who have a pregnant woman in their household, the pregnant woman is counted, at State option, as either 1 or 2 person(s) or as herself plus the number of children she is expected to deliver. Parent means a natural or biological, adopted or step parent. Sibling means natural or biological, adopted, half, or step sibling. Tax dependent has the meaning provided in § 435.4 of this part. (c) 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. (d) 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.

12. 42 C.F.R § 435.831(b) provides the following: Determining countable income. For purposes of determining medically needy eligibility under this part, the agency must determine an individual's countable income as follows: (1) For individuals under age 21, pregnant women, and parents and other caretaker relatives, the agency may apply - (i) The AFDC methodologies in effect in the State as of August 16, 1996, consistent with § 435.601 (relating to financial methodologies for non-MAGI eligibility determinations) and § 435.602 (relating to financial responsibility of relatives and other individuals for non-MAGI eligibility determinations); or (ii) The MAGI-based methodologies defined in § 435.603(b) through (f). If the agency applies the MAGI-based methodologies defined in § 435.603(b) through (f), the agency must comply with the terms of § 435.602, except that in applying § 435.602(a)(2)(ii) to individuals under age 21, the agency may, at State option, include all parents as defined in § 435.603(b) (including stepparents) who are living with the individual in the individual's household for purposes of determining household income and family size, without regard to whether the parent's income and resources would be counted under the State's approved State plan under title IV-A of the Act in effect as of July 16, 1996, if the individual were a dependent child under such State plan.

13. 42 C.F.R § 435.603(h)(1) provides as follows: Applicants and new enrollees. 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.

14. 42 C.F.R § 435.603(h)(3) provides as follows: 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.

Access Health correctly determined the current income limit for a household comprised of three (3) individuals under the Husky A Medicaid coverage group is $4,165.00 per month.

Access Health correctly determined that the household's countable MAGI exceeded the income standard.

Access Health correctly determined that the Applicant is therefore ineligible for Husky A Medicaid coverage for Children.

It should be noted, that if the additional deductions that the Appellant reported during the proceedings had been reported at the time of the application the household's MAGI would remain above the income limit thus rendering the Applicant ineligible for Husky A Medicaid coverage for Children.

14. 42 C.F.R § 457.310 provides as follows: Target lot-income child: (a) Definition. A targeted low-income child is a child who meets the standards set forth below and the eligibility standards established by the State under § 457.320. (b) Standards. A targeted low-income child must meet the following standards: (1) Financial need standard. A targeted low-income child: (i) Has a household income, as determined in accordance with § 457.315 of this subpart, at or below 200 percent of the Federal poverty level for a family of the size involved; (ii) Resides in a State with no Medicaid applicable income level; (iii) Resides in a State that has a Medicaid applicable income level and has a household income that either— (A) Exceeds the Medicaid applicable income level for the age of such child, but not by more than 50 percentage points; or (B) Does not exceed the income level specified for such

child to be eligible for medical assistance under policies of the State plan under title XIX on June 1, 1997. (2) No other coverage standard. A targeted low-income child must not be— (i) Found eligible or potentially eligible for Medicaid under policies of the State plan (determined through either the Medicaid application process or the screening process described at § 457.350), except for eligibility under § 435.214 of this chapter (related to coverage for family planning services); (ii) Covered under a group health plan or under health insurance coverage, as defined in section 2791 of the Public Health Service Act, unless the plan or health insurance coverage program has been in operation since before July 1, 1997 and is administered by a State that receives no Federal funds for the program's operation. A child is not considered covered under a group health plan or health insurance coverage if the child does not have reasonable geographic access to care under that plan.

Access Health correctly determined that the Applicant has credible health coverage and is therefore ineligible for Husky B – Band 1.

15. 42 C.F.R § 435.912(a)(1) provides as follows: “Timeliness standards” refer to the maximum period of time in which every applicant is entitled to a determination of eligibility, subject to the exceptions in paragraph (e) of this section.

16. 42 C.F.R § 435.912(c)(3) provides as follows: Except as provided in paragraph (e) of this section, the determination of eligibility for any applicant may not exceed—

    (i) Ninety days for applicants who apply for Medicaid on the basis of disability; and

    (ii) Forty-five days for all other applicants.

17. 42 CFR § 435.917(a) provides as follows: Notice of eligibility determinations. Consistent with §§ 431.206 through 431.214 of this chapter, the agency must provide all applicants and beneficiaries with timely and adequate written notice of any decision affecting their eligibility, including an approval, denial, termination or suspension of eligibility, or a denial or change in benefits and services.

    Access Health timely and correctly issued the Appellant a Notice (1301) that advised that the Applicant is ineligible for medical benefits under both the Husky A and the Husky B Health Medicaid coverage groups.

DISCUSSION

The Appellant provided credible testimony to support that the Applicant's genetic medical condition coupled with the recent change in the household's private health insurance coverage will likely increase out-of-pocket medical costs. However, I find that the testimony and evidence support that Access Health correctly determined that the Applicant did not pass the MAGI standard. Therefore, Access Health correctly determined that the Applicant is ineligible for Husky A Medicaid for Children. Furthermore, I find that Access Health correctly determined that the Applicant is ineligible for Husky B – band 1 coverage as she receives credible health insurance coverage.

DECISION

The Appellant's appeal is DENIED.

Jessica Gulianello

Jessica Gulianello
Hearings Officer

Cc: 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 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, 25 Sigourney Street, Hartford, CT 06106.

There is no right to request reconsideration for denials or reductions of Advanced Primary Tax Credits (APTC) or Cost Sharing Reduction (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, 25 Sigourney Street, Hartford, CT 06106. 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.