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

[redacted] **2024**
Signature Confirmation

Case ID # [redacted]
Client ID # [redacted]
Hearing Request # 231530

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, the Health Insurance Exchange Access Health CT ("AHCT") sent [redacted], ("the Appellant") a Notice of Action denying Medicaid/Husky D healthcare coverage.

On [redacted] 2024, the Appellant requested a hearing to contest the denial of such benefits.

On [redacted] 2024, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2024.

On [redacted] 2024, 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:

[redacted], Appellant
Debra Henry, Health Insurance Exchange, Access Health CT Representative
Scott Zuckerman, Hearing Officer

STATEMENT OF THE ISSUE

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

FINDINGS OF FACT

1. On [redacted] 2024, the Appellant submitted a change reporting application through the Access Health, Health Insurance Exchange system. The change was a redetermination. (Exhibit 2: Application ID 12226060)

2. On [redacted], 2024, the Appellant reported a total monthly income of $2160.00 and $0.00 deductions. (Appellant's testimony and Exhibit 2)

3. The Appellant files taxes as a single individual with no dependents. The Appellant is a household of one. (Exhibit 2)

4. On [redacted], 2024, AHCT sent the Appellant notice; We updated your Health Care Application, denying HUSKY D Medicaid. The notice stated the reason for the denial is "you are in a household of $2160.00 of monthly income. The income limit for a household size of 1 is $1677.00" (Exhibit. 4: We Updated your Health Care Application, [redacted]/24)

5. The monthly Federal Poverty Limit ("FPL") for a family of one at the time of the renewal was $1,215.00. (Federal Register, Volume 88, No. 12/[redacted], 2023, pp. 3424-3425).

6. 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], 2024. Therefore, this decision is due not later than [redacted], 2024. (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. Title 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 (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.

7. Title 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.

8. Title 26 of the United States Code ("U.S.C.") § 36B(d)(2)(B) provides that 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.

9. Title 42 C.F.R. § 435.945(a) provides that except where the law requires other procedures (such as for citizenship and immigration status information), the agency may accept attestation of information needed to determine the eligibility of an individual for Medicaid (either self-attestation by the individual or attestation by an adult who is in the applicant's household, as defined in §435.603(f) of this part, or family, as defined in section 36B(d)(1) of the Internal Revenue Code, an authorized representative, or, if the individual is a minor or incapacitated, someone acting responsibly for the individual) without requiring further information (including documentation) from the individual.

10. Title 42 C.F.R. § 435.603(h)(1) provides for the budget period for 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. (2) Provides for the budget period of 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.

    The Appellant's attestation that her monthly income is $2160.00 was acceptable proof of her income without further documentation. The Appellant's MAGI income at the time of her renewal was $2,160.00.

11. 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.

    The Appellant files as head of household. She is a MAGI household of one person.

12. 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.

    Five percent of the FPL for a family of one is $61.00 ($1,215.00 x 5% = $60.75 rounded to the nearest whole dollar).

    The Appellant's adjusted MAGI for purposes of her Husky D eligibility determination equaled $2099.00 [$2160.00 - $61.00 = $2099.00] monthly.

    The Appellant's $2,099.00 adjusted MAGI exceeded the $1616.00 Husky D income limit for a household of one.

13. 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.

One hundred thirty-three percent of the FPL for a household of one equaled $1,616.00 [$1,215.00 x 133% = $1,615.95 (rounded to the nearest whole dollar)]. The income limit for HUSKY D for a household of one person at the time of the Appellant's renewal was $1,616.00.

Five percent of the FPL for a family of one is $61.00 ($1,215.00 x 5% = $60.75 rounded to the nearest whole dollar).

The Appellant's adjusted MAGI for purposes of her Husky D eligibility determination equaled $2099.00 [$2160.00 - $61.00 = $2099.00] monthly.

The Appellant's $2,099.00 adjusted MAGI exceeded the $1616.00 Husky D income limit for a household of one.

[AHCT's notice stated that the income limit was $1,677.00. Rather than subtracting 5% of the FPL from the income as required in 42 C.F.R. § 435.603(d), the 5% was added to the income limit, therefore the notice reflected a limit of $1,677.00 (138% of the FPL) instead of $1,616.00 (133% of the FPL).]

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

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

DECISION

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

Scott Zuckerman
Scott Zuckerman
Hearing Officer

Pc: Becky Brown, Health Insurance Exchange, Access Health CT
Mike Towers, Health Insurance Exchange, Access Health CT
Debra Henry, Health Insurance Exchange, Access Health CT

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, 165 Capitol Avenue, 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 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.