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

Client ID [redacted]
Case ID [redacted]
Request # 241575

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 ("NOA) terminating her medical coverage under the Medicaid Husky D - Adult plan ("Husky D").

On [redacted] 2024 the Appellant submitted a request for an administrative hearing to contest AHCT's decision to end her medical coverage under the Husky D program.

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, the Appellant requested a continuance which OLCRAH granted.

On [redacted] 2025, the 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 Statutes, Chapter 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 called in for the hearing:

[redacted] Appellant
[redacted], Witness for the Appellant
Debra Henry, AHCT Representative
Lisa Nyren, Fair Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether AHCT correctly terminated the Appellant's medical coverage under the Medicaid Husky D program ("Husky D").

FINDINGS OF FACT

1. The Appellant is a recipient of Medicaid under the Husky D program. (Hearing Record)

2. The Appellant works part time for [redacted] (the "employer"). The Appellant's work hours vary because she fills in for co-workers who may be out sick or on vacation. The Appellant reported the following gross pays:

   - [redacted] 2024 $860.00
   - [redacted] 2024 $924.00
   - [redacted] 2024 $1,034.00
   - [redacted] 2024 $1,148.00

   (Appellant Testimony)

3. The Appellant is [redacted] years old. (Exhibit 3: Eligibility Determination)

4. The Appellant is single and files taxes as single. (Exhibit 2: Application and Appellant Testimony)

5. On [redacted] 2024, AHCT completed a change reporting application on behalf of the Appellant which listed the Appellant's annual income as $20,000.00; monthly income as $1,975.69; and biweekly income as $914.67. AHCT determined the Appellant ineligible for Husky D because the Appellant's monthly household income of $1,975.00 exceeds the Husky D income limit of $1,732.00 for a household of one. (Hearing Record)

6. On [redacted] 2024, AHCT issued a notice to the Appellant. The notice stated the Appellant did not qualify for Husky D-Adult health coverage because her income of $1,975.00 per month exceeds the Husky D income limit of $1,732.00. (Exhibit 4: Notice of Action)

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

CONCLUSIONS OF LAW

1. Section 17b-260 of the Connecticut General Statute ("Conn. Gen. Stat.") provides as follows:

   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. "Husky D or Medicaid Coverage for the Lowest Income Populations program means Medicaid provided to non-pregnant low-income adults who are age 18 to sixty-four, as authorized pursuant to section 17b-8." Conn. Gen. Stat. § 17b-290(16)

3. State statute provides in pertinent part as follows:

   For coverage dates on or after January 1, 2014, the department shall use the modified adjusted gross income financial eligibility rules set forth in Section 1902(e)(14) of the Social Security Act and the implementing regulations to determine eligibility for Husky A, Husky B and Husky D applicants, as defined in section 17b-290.

   Conn. Gen. Stat. § 17b-261(a)

4. State statute provides as follows:

   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.

   Conn. Gen. Stats. § 17b-264

5. Title 45 section 155.110(a) of the Code of Federal Regulations ("C.F.R.") 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.

"Exchange eligibility appeals may be conducted by a State Exchange appeals entity, or an eligible entity described in paragraph (d) or 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(c)(1)

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

6. Federal regulation provides for coverage for individual age 19 or older and under age 65 at or below 133 percent FPL.

a. *Basis*. This section implements section 1902(a)(10)(A)(i)(VIII) of the Act.
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 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.

    42 C.F.R. § 435.119

The 2024 Federal Poverty Limit ("FPL") for a household of one in the 48 Contiguous States and the District of Columbia is $1,255.00 per month as set by the U.S. Department of Health and Human Services annually. ($15,060.00 per year / 12 months = $1,255.00 per month) [Federal Register, Vol. 89, No. 11, January 17, 2024, pp. 2962]

133% of the FPL is $1,669.00 per month. ($1,255.00 FPL x 133% = $1,669.15 per month) The Husky D income limit equals $1,669.00 per month.

AHCT correctly determined the Appellant's eligibility under the Husky D program for individuals ages 19 or older and under age 65.

7. “The exchange must verify MAGI-based income, within the meaning of 42 CFR 435.603(d), for the household described in paragraph (c)(2)(i) in accordance with the procedures specified in Medicaid regulations 42 CFR 435.945, 42 CFR 435.948, and 42 CFR 435.952 and CHIP regulations at 42 CFR 457.380.” 45 C.F.R. § 155.320(c)(2)(ii)

   Federal regulation provides as follows:

   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.

   42 C.F.R. § 435.945(a)

   “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 individual identifies in paragraph (j) of this section and as provided in paragraph (a)(3) of this section.” 42 C.F.R. § 435.603(a)(2)

8. Federal regulation provides as follows:

   For the purpose of this section - *family size* as 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 individual 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.

   42 C.F.R. § 435.603(b)

   Federal regulation provides as follows:

   Basic rule for taxpayers not claimed as a tax dependent. In the case of an individual who expects to file a tax return for the taxable year in which an initial determination of renewal of eligibility is being made, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to paragraph (f)(5) of this section, all persons who such individual expects to claim as a tax dependent.

42 C.F.R. § 435.603(f)(1)

AHCT correctly determined a household of one under the Husky D program because the Appellant's household consists of herself, the taxpayer who does not expect to be claimed as a tax dependent by another taxpayer.

9. "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." 42 C.F.R. § 435.603(c)

"Household income-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." 42 C.F.R. § 435.603(d)(1)

10. Federal regulation 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.

42 C.F.R. § 435.603(d)(4)

Five percent (5%) of the FPL for a household of one equals 63.00. ($1,255.00 x 5% = $62.75)

11. Federal regulation provides as follows:

MAGI-based income. For the purposes of this section, 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. Provides for American Indian/Alaska Native exceptions.

42 C.F.R. § 435.603(e)

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.

Federal regulation 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.

42 C.F.R. § 435.603(h)(3)

"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." 42 C.F.R. § 435.603(h)(1)

Federal regulation provides as follows:

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.

42 C.F.R. § 435.603(h)(2)

The Department elected in its State plan to base financial eligibility on current monthly household income. [Centers for Medicare and Medicaid Services, Division of Medicaid and Children's Health Operations State Plan Amendment # 14-0003-MM3 effective January 1, 2014, August 25, 2014]

Based on the hearing record, AHCT's calculation of the Appellant's monthly gross income as $1,976.69 cannot be determined. However, the hearing record confirms the Appellant's countable monthly gross income of

$1,854.80 exceeds the Husky D income limit of $1,669.00 for a household of one, therefore AHCT's [redacted] 2024 action to terminate the Appellant's medical coverage under the Husky D program is upheld.

The correct monthly gross income is $1,917.80 based on [redacted] 2024 actual bi-weekly pays as reported by the Appellant.
[redacted]/24 gross pay $860.00 + [redacted]/24 gross pay $924.00 = $1,784.00 / 2 weeks = $892.00 bi-weekly wages x 2.15 weeks = $1,917.80 gross monthly income

The correct monthly countable income equals $1,854.80. ($1,917.80 gross monthly income - $63.00 5% of FPL = $1,854.80 monthly countable income)

At the hearing, the Appellant reported her wages increased resulting in increased monthly income further supporting the Appellant's ineligibility for medical coverage under the Husky D program because her monthly countable income exceeds the Husky D income limit.
[redacted]/24 gross pay $1,034.00 + [redacted]/24 gross pay $1,148.00 = $2,182.00 / 2 weeks = $1,091.00 bi-weekly x 2.15 weeks = $2,345.68 gross monthly income $2,345.68 gross monthly income - $63.00 5% of the FPL = $2,282.68 countable income

Although AHCT calculated the Medicaid Husky D program income limit as $1,732.00 by adding 5% of the 2024 FPL $63.00 to the Medicaid income limit for a household of one $1,669.00 rather than subtracting the 5% of the FPL from the Appellant's gross wages, the result is the same. The Appellant's income of $1,917.80 per month exceeds the Medicaid income limit of $1,732.00 per month.

AHCT correctly determined the Appellant ineligible for Husky D because the Appellant's countable income exceeds the Husky D income limit for a household of one.

On [redacted] 2024, AHCT correctly determined the Appellant does not qualify for Medicaid benefits under the Husky D program and issued the Appellant notification of the closure of medical coverage under the Husky D program.

DECISION

The Appellant's appeal is denied.

Lisa A. Nyren

Lisa A. Nyren
Fair Hearing Officer

CC: Debra Henry, AHCT
Becky Brown, AHCT
Danielle Valente, DSS
Shannon Laplante, DSS
Allison Doyle, DSS
Christina Rodriguez, AHCT

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 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 extensions final and is not subject to review or appeal.