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

[redacted] **2018**
Signature Confirmation

Client # [redacted]
Hearing # [redacted]

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2018, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a notice of action discontinuing her Medicaid for the Employed Disabled program.

On [redacted], 2018, the Appellant's attorney, [redacted], requested an administrative hearing to contest the Department's decision to discontinue her Medicaid benefits.

On [redacted] 2018, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") issued a notice scheduling the administrative hearing for [redacted] 2018.

On [redacted], 2018, the Appellant did not appear for the administrative hearing.

On [redacted] 2018, the Appellant's attorney requested the administrative hearing be rescheduled.

On [redacted], 2018, OLCRAH issued a notice rescheduling the administrative hearing for [redacted] 2018.

On [redacted] 2018, the Appellant did not appear for the administrative hearing.

On [redacted] 2018, the Appellant's attorney requested the administrative hearing be rescheduled.

On [redacted], 2018, OLCRAH issued a notice rescheduling the administrative hearing or [redacted] 2018.

On [redacted], 2018, the Appellant's attorney requested the administrative hearing be rescheduled.

On [redacted] 2018, OLCRAH issued a notice rescheduling the administrative hearing on [redacted] 2018.

On [redacted] 2018, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals participated in the hearing:

[redacted], Appellant
[redacted], Esq, Appellant's attorney
Garfield White, Department's Representative
Scott Zuckerman, Hearing Officer

The hearing record remained open for the submission of additional evidence from the Appellant. On [redacted], the hearing record closed.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly discontinued the Appellant's Medical assistance through the Medicaid for the Employed Disabled program.

FINDINGS OF FACT

1. On [redacted] 2018, the Department received the Appellant's renewal for the Medicaid for the employed disabled program. (Hearing Summary)

2. The Appellant is single. (Hearing Record)

3. The Appellant is employed a clinical psychologist. (Appellant's testimony)

4. The Appellant Sixty – four (64) years old. (Hearing Record)

5. The asset limit for a single individual under the Medicaid for the employed disabled program is $10,000. (Hearing record)

6. The Appellant has a 403(b) retirement account managed through [redacted] with a vested amount of $66,094.61. (Departments Exhibit 6: [redacted]t statement [redacted] 2018, Appellant's

Exhibit K: [redacted] plan account summary [redacted] 2018)

7. The Appellant has a 401(K) retirement plan through [redacted] care with a vested amount of $51,856.55. (Exhibit 1 and Exhibit L: [redacted] 401K plan account summary dated [redacted], 2018)

8. The Appellant has a [redacted] 403b, participant Id [redacted] with a value of $41,221.33 as of [redacted] 2018. (Exhibit I: Metlife [redacted] 403B statement)

9. The Appellant is the owner of [redacted] traditional IRA # [redacted] with a balance of $20,365.65. (Ex. H: [redacted] account details dated [redacted] 2018)

10. The Appellant is the owner of [redacted] retirement plan [redacted] with a balance of $29,969.48. (Exhibit M: [redacted] statement [redacted] 2018 – [redacted], 2018)

11. The Appellant is the owner of [redacted] IRA # [redacted] with a value of $36,904.29. (Exhibit N: [redacted] account statement [redacted] 2018 – [redacted] 2018)

12. The Appellant is the owner of [redacted] Life insurance policy # [redacted] The policy has a face value of $50,000 and cash surrender value of $8,290.67 as of [redacted] 2017. (Exhibit J: [redacted] Insurance policy statement dated [redacted] 2017)

13. There was no evidence presented of the Metlife Life insurance cash surrender value at the time of the [redacted] discontinuance. (Hearing Record)

14. The Appellant is the owner of Webster bank checking account [redacted] with an ending balance of $575.43 as of [redacted] 2018. (Exhibit O: Webster bank transaction history, [redacted]/18)

15. There was no evidence presented of the Webster bank checking account balance at the time of the [redacted] discontinuance. (Hearing Record)

16. The Appellant is the owner of TD Bank checking account [redacted] with an ending balance of $1,358.64 as of [redacted], 2018. (Exhibit P: TD Bank transaction history [redacted] 18 – [redacted]/18)

17. There was no evidence presented of the TD bank checking account balance at the time of the [redacted] 2018 discontinuance. (Hearing Record)

18. The Appellant is the owner of Capital One savings account [redacted] with an ending balance of $5080.17 as of [redacted] 2018. (Exhibit Q: Capital One Savings summary, [redacted]/18)

19. There was no evidence presented of the Capital One Savings account balance at the time of the [redacted]2018 discontinuance. (Hearing Record)

20. On [redacted], 2018, the Department mailed the Appellant a Notice of Action. The notice stated that the Appellant's Husky C was discontinued because the value of her assets are more than the amount the Department allows. (Exhibit 7: Notice of Action, [redacted]/18)

21. 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], 2018. However, the hearing, which was originally scheduled for [redacted] 2018, was rescheduled several times at the request of the Appellant (see Procedural Background) to [redacted] 2018, which caused a 106 day delay. The Appellant requested the hearing record remain open for the submission of additional evidence, which caused an additional 10 day delay. Because this 116 day delay resulted from the Appellant's request, this decision is not due until [redacted], 2018, and is therefore timely.

CONCLUSIONS OF LAW

1. Connecticut General Statutes §17b-2 provides that 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.

2. Uniform Policy Manual ("UPM") § 2015.05(A) provides that the assistance unit in assistance to the Aged, Blind or Disabled ("AABD") and MAABD consists of only one member. In these programs, each individual is a separate assistance unit.

   UPM § 5500.01 provides that a needs group is the group of persons comprising the assistance unit and certain other persons whose basic needs are added to the total needs of the assistance unit members when determining the income eligibility of the assistance unit.

   UPM § 5515.05(C)(2) provides that the needs group for an applicant or recipient under the MAABD program includes the following:

   a. the applicant or recipient; and
   b. the spouse of the applicant or recipient when they share the same home regardless of whether one or both are applying for or receiving assistance, except in cases involving working individuals with disabilities. In these cases, the spouse (and children) are part of the needs group only in determining the cost of the individual's premium for medical coverage (Cross Reference: 2540.85)

The Department correctly determined that the Appellant is a needs group of one and an assistance unit of one.

3. Connecticut General Statutes §17b-597(a) provides the Department of Social Services shall establish and implement a working persons with disabilities program to provide medical assistance as authorized under 42 USC 1396a(a)(10)(A)(ii), as amended from time to time, to persons who are disabled and regularly employed. (b) The Commissioner of Social Services shall amend the Medicaid state plan to allow persons specified in subsection (a) of this section to qualify for medical assistance. The amendment shall include the following requirements: (1) That the person be engaged in a substantial and reasonable work effort as determined by the commissioner and as permitted by federal law and have an annual adjusted gross income, as defined in Section 62 of the Internal Revenue Code of 1986, or any subsequent corresponding internal revenue code of the United States, as amended from time to time, of no more than seventy-five thousand dollars per year; (2) a disregard of all countable income up to two hundred per cent of the federal poverty level; (3) for an unmarried person, an asset limit of ten thousand dollars, and for a married couple, an asset limit of fifteen thousand dollars; (4) a disregard of any retirement and medical savings accounts established pursuant to 26 USC 220 and held by either the person or the person's spouse; (5) a disregard of any moneys in accounts designated by the person or the person's spouse for the purpose of purchasing goods or services that will increase the employability of such person, subject to approval by the commissioner; (6) a disregard of spousal income solely for purposes of determination of eligibility; and (7) a contribution of any countable income of the person or the person's spouse which exceeds two hundred per cent of the federal poverty level, as adjusted for the appropriate family size, equal to ten per cent of the excess minus any premiums paid from income for health insurance by any family member, but which does not exceed the maximum contribution allowable under Section 201(a)(3) of Public Law 106-170, as amended from time to time. (c) The Commissioner of Social Services shall implement the policies and procedures necessary to carry out the provisions of this section while in the process of adopting such policies and procedures in regulation form, provided notice of intent to adopt the regulations is published in the Connecticut Law Journal within twenty days after implementation. The commissioner shall define "countable income" for purposes of subsection (b) of this section which shall take into account impairment-related work expenses as defined in the Social Security Act. Such policies and procedures shall be valid until the time final regulations are effective.

   UPM § 2540.85 provides there are two distinct groups of employed individuals between the ages of 18 and 64 inclusive who have a medically certified disability or blindness and who qualify for Medicaid as working individuals with disabilities. These groups are the Basic Insurance Group and the Medically Improved Group. There is a third group of employed individuals consisting of persons at least 18 years of age who have a medically certified disability or blindness who also qualify for Medicaid as working individuals with disabilities. This is the Balanced Budget Act Group. Persons in this third group may be age 65 or older.

4. UPM § 2540.85 (A) (3) provides for the asset criteria. a. The asset limit is $10,000.00 for an individual and $15,000.00 for a married couple living together. b. In addition to the assets excluded under the Medicaid program, the following assets are also excluded: (1) retirement and medical savings accounts established pursuant to 26 USC 220 and held by either the individual or his or her spouse; and (2) accounts held by the individual or spouse and designated by such person as being held for the purpose of buying goods or services that will increase the employability of the individual. Such accounts are subject to the approval of the Department. c. The assets excluded in section 2540.85 A. 3. b. retain their excluded status for the life of the individual, even if he or she loses eligibility under this coverage group.

5. UPM § 2540.85 (B) provides for the medically improved group. 1. An individual in this group, which is authorized under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), must have been eligible for Medicaid pursuant to paragraph A above, but must have lost such eligibility because of a medical improvement determined at the time of a regularly scheduled continuing disability review. 2. An individual in the Medically Improved group is subject to the same conditions described in section 2540.85 A. 2. through 4. concerning the income eligibility tests, asset eligibility tests, and computation of premiums. 3. The eligibility requirements with respect to disability status and the definition of employment are as follows for individuals in the Medically Improved group: a. The individual must continue to have a severe medically determinable impairment. However, the impairment does not need to meet the medical criteria to the same extent as for those in the Basic Insurance group. b. The individual meets the employment criterion if he or she is earning a monthly wage equal to or greater than the federal minimum hourly wage times 40. There is no extension of coverage under this group once the individual loses employment.

   The Appellant is deemed eligible for the Medically Improved group.

6. UPM § 4030.05(A) provides that bank accounts include the following. This list is not all inclusive: 1. Savings account; 2. Checking account; 3. Credit union account; 4. Certificate of deposit; 5. Patient account at long-term care facility; 6. Children's school account; 7. Trustee account; 8. Custodial account.

   UPM § 4030.05 (D) provides for excluded accounts for working individuals with disabilities. The following assets are excluded in determining the Medicaid eligibility of working individuals with disabilities (Cross Reference: 2540.85): 1. retirement and medical savings accounts established pursuant to 26 USC 220 and held by either the individual or his or her spouse; and 2. accounts held by the individual or spouse and designated by such person as being held for the purpose of buying goods or services that will increase the employability of the individual. Such accounts are subject to the approval of the Department.

   UPM § 4030.30 (A) provides for treatment of life insurance policies. (1) The owner of a life insurance policy is the insured unless otherwise noted on the policy, or if the

insurance company confirms that someone else, and not the insured can cash in the policy. (2) Policies such as term insurance policies having no cash surrender value are excluded assets.

UPM § 4030 (C) (1) provides that if the total face value of all life insurance policies owned by the individual does not exceed $1,500, the cash surrender value of such policies is excluded. In computing the face value of life insurance, the Department does not count insurance such as term insurance which has no cash surrender value.

UPM § 4030 (C) (2) provides that except as provided above, the cash surrender value of life insurance policies owned by the individual is counted towards the asset limit.

UPM § 4099.05 (A) provides for asset limit requirement. 1. The assistance unit must verify its equity in counted assets. 2. If the unit does not verify its equity in counted assets, the unit is ineligible for assistance.

The Department incorrectly determined that the Appellant's retirement accounts are included assets in determining eligibility for the Medicaid for the Employed disabled program. The retirement accounts are excluded assets when determining eligibility for the program.

The Appellant's life insurance policy cash surrender value has a face value over $1500 and is therefore a countable asset.

There is no indication in the hearing record that the Department requested verification of the current cash surrender value of the policy.

The Appellant's savings and checking accounts are included assets in determining eligibility for the Medicaid for the Employed Disabled program.

There is no indication in the hearing record that the Department requested current bank statements at the time of determining eligibility for the program.

DECISION

The Appellant's appeal is **REMANDED BACK TO THE DEPARTMENT FOR FURTHER ACTION.**

ORDER

1. The Department shall reopen the Appellant's Medicaid for the employed disabled and issue the Appellant a request for proofs for the following **as of [redacted] 2018***:*

(a) Metlife Life Insurance cash surrender value.
(b) Capital One savings account balance
(c) Webster bank checking account balance.
(d) TD bank checking account balance.

2. The Department will exclude all of the Appellant's retirement account assets from consideration in determining eligibility for the program.

3. Providing all eligibility factors are provided and verified, the Department will determine the Appellant's eligibility for the Medicaid for the employed disabled program and issue a Notice of Action.

4. Compliance with this order shall be forwarded to the undersigned no later than [redacted], 2018.

Scott Zuckerman
Hearing Officer

Cc: Musa Mohamud, Operations Manager, DSS, Hartford Regional Office
Judy Williams, Operations Manager, DSS, Hartford Regional Office
Jessica Carroll, Operations Manager, DSS, Hartford Regional Office
Jay Bartolomei, DSS, Fair Hearing Liaison Supervisor, Hartford Regional Office
Garfield White, DSS, Fair Hearing Liaison, Hartford Regional Office

RIGHT TO REQUEST RECONSIDERATION

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 Administrative Hearings and Appeals, 55 Farmington Avenue Hartford, CT 06105.

RIGHT TO APPEAL

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 the Commissioner's 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.