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

[redacted], 2019
Signature Confirmation

Case ID # [redacted]
Client ID # [redacted]
Request # [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 ("S05") effective [redacted]/18 because she did not make the required premium payments.

On [redacted], 2019, the Appellant requested an administrative hearing to appeal the Department's discontinuance of her S05 assistance.

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-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, OLCRAH held an administrative hearing.

The following individuals participated at the hearing:

[redacted], Appellant
[redacted], Appellant's Son
Christine Faucher, Department's Representative
Christopher Turner, Hearing Officer

STATEMENT OF THE ISSUE

The issue to be decided is whether the Department correctly discontinued the Appellant's S05 coverage due to having an overdue premium.

FINDINGS OF FACT

1. [redacted], 2018, the Appellant submitted an application for S05 benefits. The Appellant was given a proofs we need form ("W-1348") requesting the Appellant provide her four most recent paystubs and bank account verification by [redacted]/18. (Exhibit 1: Application; Exhibit 2: W-1348; Exhibit 4: Case notes; Hearing summary)

2. On [redacted], 2018, the Department received the Appellant's requested verifications. (Exhibit 4; Hearing summary)

3. On [redacted], 2018, the Department granted the Appellant's S05 application. A Med-Connect premium invoice was sent to the Appellant indicating her S05 premium would be [redacted] monthly. In addition, the notice showed the Appellant had a total premium amount due of [redacted] that included the months of [redacted] 2017 through [redacted] 2017. (Exhibit 8A: Med-Connect Premium Invoice)

4. On [redacted], 2018, the Department sent the Appellant a Med-Connect premium invoice indicating her S05 assistance will end [redacted], 2018 if her premium payments for the months of [redacted] 2017 through [redacted] 2017 as well as [redacted] 2018 through [redacted] 2018 are not received by the last day of [redacted] 2018. (Exhibit 8B: Med-Connect Premium Invoice)

5. On [redacted], 2018, the Department discontinued the Appellant's S05 for failure to pay premiums by the due date. (Exhibit 6: Notice dated 12/31/18)

6. On [redacted], 2019, the Appellant requested an administrative hearing. (Record)

7. The Appellant is [redacted] years old [redacted]. (Exhibit 1)

8. The Appellant receives $[redacted] in Social Security Disability Income. (Exhibit 1)

9. The Appellant's monthly premium charges and payments are as follows:

Benefit Month	Premium Amount	Payment Amount	Balance
[redacted] 2017	[redacted]	$0.00	[redacted]
[redacted] 2017	[redacted]	$0.00	[redacted]
[redacted] 2017	[redacted]	$0.00	[redacted]
[redacted] 2017	[redacted]	$0.00	[redacted]
[redacted] 2018	[redacted]	$0.00	[redacted]
[redacted] 2018	[redacted]	$0.00	[redacted]

[redacted] 2018	$55.47	$55.47	$343.86

(Exhibit 7: S05 Balance summary)

10. The Appellant testified she did not pay her [redacted] 2017, [redacted] 2017, and [redacted] 2018 through [redacted] 2018 premiums. The Appellant did pay her [redacted] 2018 premium. (Exhibit 7; Appellant's testimony)

11. The Department agreed to remove the [redacted] 2017 and [redacted] 2017 premium amounts leaving an outstanding balance of $[redacted]. ($[redacted]). (Department representative's testimony)

12. The issuance of this decision is timely under section 17b-61(a) of Connecticut General Statutes, 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], 2019 and this decision, therefore, was due no later than [redacted], 2019. (Hearing record)

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. Connecticut General Statues § 17b-597 provides for a working persons with disabilities program. (a) 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.

Uniform Policy Manual ("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.

UPM § 2540.85(A) provides for the Basic Insurance Group. An individual in this group, which is authorized under the Ticket to Work and Work Incentives Improvement Act of 1999 (TWWIIA), is subject to the conditions described below. 1. An individual in this group must be engaged in a substantial and reasonable work effort to meet the employment criterion. (a) Such effort consists of an activity for which the individual receives cash remuneration and receives pay stubs from his or her employer. (b) If the individual is self-employed, he or she must have established an account through the Social Security Administration and must make regular payments based on earnings as required by the Federal Insurance Contributions Act. (c) that an individual who meets the employment criterion but then loses employment through no fault of his or her own, for reasons such as a temporary health problem or involuntary termination, continues to meet the employment criterion for up to one year from the date of the loss of employment. The individual must maintain a connection to the labor market by either intending to return to work as soon as the health problem is resolved, or by making a bona fide effort to seek employment upon an involuntary termination.

The Department correctly determined the Appellant was eligible for the Basic Insurance Group as she is working and receives pay stubs from her employer.

3. UPM § 2540.85(A)(4) provides the individual may be required to pay the Department a monthly premium for medical coverage if the gross monthly counted income of the individual and spouse (minus Impairment-Related Work Expenses described at UPM 5035.10 C) exceeds 200% of the federal poverty level (FPL) for the appropriate family size, including dependent children living in the home.

   UPM § 3545.15(A)(1) provides individuals receiving Medicaid as Working Individuals with Disabilities may be required to pay the Department a premium for Medicaid coverage if the individual's gross income, plus the gross income of his or her spouse, minus Impairment-Related Work Expenses, exceeds 200 percent of the federal poverty level for the appropriate family size.

UPM § 3545.15(A)(5) provides an individual owing the Department a monthly Medicaid premium must pay the premium by the end of the month for which coverage is requested.

UPM § 3545.15(B)(1) provides an individual is not eligible for Medicaid coverage if he or she fails to pay the Medicaid premium by the date due.

UPM § 3545.15(B)(2) provides if a Medicaid recipient fails to pay the Medicaid premium by the date due, his or her benefits are terminated at the end of the following month.

UPM § 3545.15(B)(3) provides individuals whose Medicaid benefits are terminated for non-payment of premium remain ineligible under this coverage group until they have paid the Department for all premiums owed.

The Department correctly discontinued the Appellant's S05 coverage effective [redacted], 2018 as the Appellant has an overdue S05 premium of $[redacted].

DECISION

The Appellant's appeal is denied.

Christopher Turner
Hearing Officer

Cc: Tricia Morelli, Operations Manager, Manchester DSS
Christine Faucher, Fair Hearing Liaison, Manchester DSS

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, law, and 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.

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, if 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.