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]
Request # 238612

NOTICE OF DECISION
PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted] 2024, the Department of Social Services (the "Department") sent [redacted] (the "Appellant") a Notice of Action ("NOA") informing the Appellant that his HUSKY C Medicaid for the Employed Disabled ("MED") coverage premium amount effective [redacted], 2024, is $107.79.

On [redacted], 2024, the Appellant's conservator requested an administrative hearing to contest the increase in premium and past-due premium amount of his MED coverage.

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's conservator requested the administrative hearing be rescheduled.

On [redacted], 2024, the OLCRAH issued a notice rescheduling the administrative hearing for [redacted], 2024.

On [redacted], 2024, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-184, inclusive, of the Connecticut General Statutes, the OLCRAH held an administrative hearing. The following individuals participated in the hearing:

[redacted] Appellant's mother and Conservator

Jasmine Barrs, Department's representative
Rebecca Mercer, Department's representative
Scott Zuckerman, Hearing Officer

The hearing record remained open for the submission of additional evidence from the Department. The information was received and the record closed on [redacted] 2024.

STATEMENT OF THE ISSUE

The issue is whether the Department correctly calculated the Appellant's MED connect premium amount effective [redacted] 2024.

FINDINGS OF FACT

1. The Appellant is thirty - one years old (DOB [redacted]/1972), and a recipient of Husky C MED coverage for a household of one. The Appellant is certified through [redacted], 2025. (Conservator's testimony, Ex. 8: Notice of Action, [redacted]/24)

2. The Appellant is employed as a custodian at the [redacted] since [redacted] 2021. The Appellant's biweekly pay is $1,668.80. (Conservator's testimony and Ex. 8: NOA, [redacted]/24)

3. On [redacted] 2021, the Appellant's Social Security Disability Income ("SSDI") ended. (Conservator's testimony, Department's testimony)

4. The Appellant does not have any impairment-related employment expenses, unpaid medical bills, or health insurance premiums. (Hearing Record)

5. On [redacted] 2024, the Department sent the Appellant an NOA. The notice informed the Appellant that based on a review of his information his premium has changed and that his new MED – Connect premium amount effective [redacted]2024 is $107.79. (Exhibit 8: NOA, [redacted]/2024)

6. On [redacted], 2024, the Department sent the Appellant a MED – Connect Premium invoice letter informing him that he has a past due amount of $4,553.12 from [redacted]2021 through [redacted]2024 and the amount due for [redacted] 2024 is $107.79. (Exhibit 1: Invoice dated [redacted]/24)

6. The Department determined the Appellant has a Family Size of one. 200% of the Federal Poverty Level ("FPL") for a Family Size of one in [redacted] 2024 was $2,510.00. (Exhibit 7: MA – S05 Working Disabled Premium screen [redacted] 2024)

7. The Department's internal S05 Balance Summary displays that the Appellant had overpaid his premiums and had a credit of $751.53 for the month of [redacted]2024. (Exhibit 6: S05 Balance Summary)

8. 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] 2024, with this decision due no later than [redacted], 2024. However, the hearing record was extended (7) days to allow for the submission of information from the Department at the request of the Appellant. This decision is therefore not due until [redacted] 2024, and is timely. (Hearing Record)

CONCLUSIONS OF LAW

1. Connecticut General Statutes ("Conn. Gen. Stat.") § 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.

The Department has the authority to administer Medicaid under the MED program.

2. "The department's Uniform Policy Manual ("UPM") is the equivalent of state regulation and, as such, carries the force of law." Bucchere v. Rowe, 43 Conn. Supp. 175, 178 (1994) (citing Conn. Gen. Stat. § 17b-10; Richard v. Commissioner of Income Maintenance, 214 Conn. 601, 573 A.2d 712 (1990)).

3. Conn. Gen. Stat. § 17b-597 provides for the 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.

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)(1) 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 is a single individual eligible for the Basic Insurance Group as he is between the ages of 18 and 65 years old, is working, and is disabled.

4. UPM § 5000.01 provides that Gross Earned Income is the total amount of counted earned income before deductions or disregards are subtracted from it. When earnings are from self-employment, the gross amount is the difference between self-employment income and self-employment expenses.

The Department correctly considered the Appellant's gross earned income of $3,587.92 per month as earned income.

5. UPM § 5025.05(B)(2) provides that if income is received on other than a monthly basis, the estimate of income is calculated by multiplying 4.3 by a representative weekly amount that is determined as follows: b. if income varies from week to week, a representative period of at least four consecutive weeks is averaged to determine the representative weekly amount. d. if income is received on other than a weekly or monthly basis, the income is converted to a representative weekly amount by dividing the income by the number of weeks covered.

The Department correctly determined the Appellant's gross monthly income at [redacted] is $3,587.92 ($1668.80 x 2.15 = $3587.92).

6. UPM § 2540.85(A)(2) provides that the individual meets the income eligibility test under this group by passing one of the following income tests: a. having a gross monthly income equal to or less than $6250; or b. having an applied monthly income (gross income minus the following: a $20 general disregard; the first $65 of gross monthly earnings; Impairment Related Work Expenses described at UPM 5035.10 C, if applicable; and 1/2 the remaining earnings) equal to or less than $3082.50.

The Department correctly determined the Appellant meets the income eligibility test for the Basic Insurance Group as his gross monthly income is less than $6,250.00.

7. 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)(2) provides the amount of the individual's monthly Medicaid premium is equal to 10% of the excess monthly income described above, minus the amount of any monthly payments for health insurance made by the individual or spouse for any family member.

UPM § 5035.10 (C) provides for Impairment Related Work Expenses. 1. Certain work expenses which are related to enabling the individuals to be employed are deducted from earned income in determining eligibility and calculating benefits for: a. recipients of assistance to the disabled; and b. recipients of assistance to the aged who received assistance to the disabled in the month before they became 65 years of age. 2. Impairment related work expenses are not used to determine the initial eligibility of an

applicant for assistance based upon disability. 3. Impairment-related work expenses include, but are not limited to, the following: a. attendant services including help with personal or employment functions; f. non-medical equipment which can be associated with enabling the individual to be employed; g. drugs and medical services directly related to reducing, controlling or eliminating an impairment or its symptoms; h. all other miscellaneous expenses not cited above but which can be associated with the individual's disability and with enabling the individual to be employed including transportation, medical supplies, vehicular medications, etc.

UPM § 2540.85(A)(4) provides that 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. a. The amount of the premium is equal to 10% of this excess, minus the monthly amount of any payments for health insurance made by the individual or spouse for any family member. b. For an individual described in this paragraph whose net family income is greater than 250% of the FPL but does not exceed 450% of the FPL for the appropriate family size, the premium for Medicaid coverage cannot exceed 7.5% of the individual's net family income. c. Net family income consists of the applied monthly income of the individual plus that of his or her spouse. (1) Applied monthly income of the individual is described in section 2540.85 A. 2. b. (2) The applied monthly income of an individual's eligible spouse is computed the same way as is the individual's. (3) The applied monthly income of an individual's ineligible spouse consists of the spouse's gross monthly income with no allowance for any disregards or deductions.

UPM § 5045.21 provides for Post-Eligibility Treatment of Income -- Premium Payment A. General Rules An individual eligible for Medicaid under the Working Individuals with Disabilities coverage group may be required to pay a monthly premium for Medicaid coverage if the gross counted income of the individual and his or her spouse, minus Impairment Related Work Expenses (IRWE's), exceeds 200% of the federal poverty level for the appropriate family size (Cross Reference: 2540.85). B. Premium Calculation The premium amount is calculated as follows: 1. Gross counted monthly income of the individual and spouse, minus IRWE's, is compared to 200% of the federal poverty level for the appropriate family size, including dependent children living in the home. 2. The premium is generally equal to 10% of the amount by which the income described in paragraph 1 exceeds 200% of the FPL, minus the amount of any payments for health insurance made by the individual or spouse for any family member (see paragraph C below). 3. If the individual's net family income, as described at 2540.85, is greater than 250% of the FPL but no greater than 450% of the FPL, the premium is equal to the lesser of the following: a. the amount described in paragraph 2 above; or b. 7.5% of the net family income. C. Offsetting Group Insurance Premiums and Medicaid Premiums 1. If 10% of the individual's excess income described in paragraph A exceeds the monthly cost of the family's health insurance, the individual continues to pay directly for the health insurance. As noted in paragraph B. 2., the cost of this insurance is factored into the computation of the individual's Medicaid premium due the Department. 2. If the monthly

cost of the individual's health insurance equals or exceeds 10% of his or her excess income described in paragraph A, the individual has no obligation to pay a Medicaid premium. If the individual has cost-effective group health insurance through his or her employer, the Department may help pay for this insurance as described at UPM 9040.

The Department correctly determined the Appellant's MED premium effective [redacted] 2024, $107.79 per month ($3,587.92 gross monthly earnings from [redacted] - $2,510.00 200% FPL = $1077.92 x .10 (10%) = $107.79).

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

The Appellant correctly paid the Department the required monthly premiums by [redacted] 2024, and had a credit of $751.53.

DECISION

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

Scott Zuckerman
Scott Zuckerman
Hearings Officer

Cc: Bradley Wheeler, Department's Representative, Norwich Regional Office
Matthew Kalarickal, SSOM, Norwich 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, 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 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.