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

[redacted] 2022
Signature confirmation

Case: [redacted]
Client: [redacted]
Request: 187191

NOTICE OF DECISION

PARTY

[redacted]

PROCEDURAL BACKGROUND

On [redacted], 2021, the Department of Social Services (the "Department") issued a *Notice of Action* to [redacted] (the "Appellant") denying her [redacted] 2021 HUSKY-C Medicaid application.

On [redacted], 2021, the Office of Legal Counsel, Regulations, and Administrative Hearings ("OLCRAH") received a hearing request filed by [redacted] (the "Conservator"), the Appellant's conservator of estate.

On [redacted] 2021, the OLCRAH scheduled the Appellant's administrative hearing for [redacted] 2022. The OLCRAH granted the Appellant's requests for postponements of the hearing.

On [redacted] 2022, in accordance with sections 17b-60, 17b-61, and 4-176e to 4-189, inclusive, of the Connecticut General Statutes, the OLCRAH held an administrative hearing by telephone conferencing. The following individuals participated:

[redacted], Conservator
John DiLeonardo, Department Representative
Eva Tar, Hearing Officer

The hearing record close [redacted] 2022.

STATEMENT OF ISSUE

The issue is whether the Department acted in accordance with State statute and regulation when it denied the Appellant's [redacted] 2021 HUSKY-C Medicaid application on [redacted] 2021.

FINDINGS OF FACT

1. The Appellant is [redacted] years old and suffers from [redacted] (Appellant Exhibit A: email w/attachments, [redacted] 2022)

2. The Appellant is a resident at [redacted], a skilled nursing facility. (Appellant Conservator Testimony)

3. The Appellant is the owner/insured/payor of [redacted] (the "Policy"). (Appellant Exhibit B: email w/attachment, [redacted] 2022)

4. The Policy has a face value of $4,972.00 and a net cash value of $1,846.74. (Appellant Exhibit B)

5. On [redacted] 2019, the Windham-Colchester Probate Court appointed Attorney Michele Ann Palulis as the Appellant's conservator of estate. (Appellant Exhibit A)

6. On [redacted] at 8:30 a.m., the Conservator faxed her [redacted] 2019 appointment, a *Chronic Illness Accelerated Death Benefit Claim Form*, a release to obtain the Appellant's medical/confidential information, and a *Section D: Licensed Healthcare Practitioner's Statement* [redacted]. (Appellant Exhibit A)

7. On [redacted] 2021, the Department received the Appellant's on-line HUSKY-C Medicaid application, electronically submitted on [redacted] 2021 at 8:54 a.m.[1] (Department Exhibit 1: Application, submitted [redacted])

8. On [redacted] 2021, the Department issued a *Verification We Need* to the Appellant requesting proof of the face and cash surrender value of the Policy by no later than [redacted] 2021. (Department Exhibit 2: *Verification We Need,* [redacted] 2021)

9. The [redacted] *Verification We Need* advised that failure to submit the requested documentation by the deadline would result in the delay or denial of the Appellant's benefits and stated in boldface type: **"There is no eligibility for Title 19 Long Term Care benefits in any month in which counted assets exceed $1,600. You must prove that your total assets are below $1,600 and also show how your funds are spent to reduce your assets below the allowable limit. Please provide copies of bills, receipts or cancelled checks that show how you reduced assets below $1,600."** (Department Exhibit 2)

[1] October 11, 2021 fell on Columbus Day, a State holiday.

10. On [redacted] 2021, the Conservator mailed verification of the cash value of the Policy and the previously submitted *Chronic Illness Accelerated Death Benefit Claim Form* to the Department. (Appellant Exhibit A)

11. On [redacted], 2021, the Department received the Conservator's [redacted] 2021 mailing. (Department Representative Testimony) (Appellant Exhibit A)

12. On [redacted] 2021, the Department issued a *Verification We Need* to the Conservator requesting submission of proof of the surrender of the Policy and how the funds were used by no later than [redacted] 2021. (Department Exhibit 3: *Verification We Need,* 1[redacted]/2021)

13. The [redacted] 2021*Verification We Need* advised that failure to submit the requested documentation by the deadline would result in the delay or denial of the Appellant's benefits and stated in boldface type: **"There is no eligibility for Title 19 Long Term Care benefits in any month in which counted assets exceed $1,600. You must prove that your total assets are below $1,600 and also show how your funds are spent to reduce your assets below the allowable limit. Please provide copies of bills, receipts or cancelled checks that show how you reduced assets below $1,600."** (Department Exhibit 3)

14. As of [redacted] 2021, the Department had not received proof of surrender of the Policy and proof of distribution of the funds received from the surrender of the Policy. (Department Representative Testimony)

15. On [redacted] 2021, the Department issued a *Notice of Action* denying the Appellant's [redacted] 2021 HUSKY-C Medicaid application; the reasons cited were: "You did not return all of the required proofs by the date we asked" and "Does not meet program requirements." (Department Exhibit 4: *Notice of Action,* [redacted])

16. On [redacted] 2021, [redacted] 2022, and [redacted] 2022, the Conservator telephoned the [redacted] (Appellant Exhibit A)

17. As of [redacted] 2022, the [redacted] had not issued an Accelerated Death Benefit on the Policy. (Conservator Testimony)

18. As of the time of this hearing, the Conservator has not submitted a request for the surrender of the Policy to [redacted] (Conservator Testimony)

19. Connecticut General Statutes § 17b-61 (a) provides: "The Commissioner of Social Services or the commissioner's designated hearing officer shall ordinarily render a final decision not later than ninety days after the date the commissioner receives a request for a fair hearing pursuant to section 17b-60, … , provided the time for rendering a final decision shall be extended whenever the aggrieved person requests or agrees to an extension…."

    On [redacted] 2021, the OLCRAH received the Conservator's online hearing request. This hearing decision ordinarily would be due no later than [redacted] 2022. However, the OLCRAH granted the Appellant a 91-day postponement of her [redacted] 2022

hearing date that extended the deadline for the issuance of this decision. This hearing decision would have become due by no later than [redacted] 2022. This decision is timely.

CONCLUSIONS OF LAW

1. Section 17b-2 of the Connecticut General Statutes in part designates the Department of Social Services as the state agency for the administration of the Medicaid program pursuant to Title XIX of the Social Security Act.

   "The Commissioner of Social Services may make such regulations as are necessary to administer the medical assistance program…." Conn. Gen. Stat. § 17b-262.

   "The department's uniform policy manual is the equivalent of a 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)).

   The Department has the authority to administer the Medicaid program in Connecticut and may make such regulations as are necessary.

2. Section 17b-80 (a) of the Connecticut General Statutes provides in part that "[t]he commissioner, upon receipt of an application for aid, shall promptly and with due diligence make an investigation, such investigation to be completed within forty-five days after receipt of the application..." and "[t]he commissioner, … , shall in determining need, take into consideration any available income and resources of the individual claiming assistance…."

   "Prior to making an eligibility determination, the Department conducts a thorough investigation of all circumstances relating to eligibility and the amount of benefits." Uniform Policy Manual ("UPM") § 1505.40 A.1.

   "The Department compares the assistance unit's equity in counted assets with the program asset limit when determining whether the unit is eligible for benefits." UPM § 4005.05 D.1.

   With respect to the Medicaid program's coverage group for the elderly or disabled, the asset limit is $1,600.00 for a needs group of one. UPM § 4005.10 A.2.a.

   The Department has the authority to review the Appellant's circumstances to determine whether her counted assets were within the HUSKY-C Medicaid program's $1,600.00 asset limit for an individual.

3. "The Department must inform the assistance unit regarding the eligibility requirements of the programs administered by the Department, and regarding the unit's rights and responsibilities." UPM § 1015.10 A.

   "MA, AABD Residents of Long Term Care Facilities. At the time of application, the assistance unit is ineligible until the first day of the month in which it reduces its equity in counted assets to within the asset limit." UPM § 4005.15 A.2.

The Department correctly informed the Conservator of the Medicaid program's $1,600.00 asset limit.

The Department correctly instructed the Conservator that the Appellant would be ineligible to participate in the Medicaid program in any month in which the Appellant's counted assets exceeded the Medicaid program's asset limit.

4. "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 § 4030.30 C.1.

   The Department correctly determined that as the Policy's $4,972.00 face value exceeded $1,500.00, the criteria provided at UPM § 4030.30 C.1.

5. "To the extent permissible under federal law, an institutionalized individual, as defined in Section 1917 of the Social Security Act, 42 USC 1396p(h)(3), shall not be determined ineligible for Medicaid solely on the basis of the cash value of a life insurance policy worth less than ten thousand dollars *provided the individual is pursuing the surrender of the policy."* Conn. Gen. Stat. § 17b-261 (h). (emphasis added)

   The Department correctly instructed the Conservator to provide proof of the surrender the Policy and provide proof of how the funds from the surrender were dispersed as a condition of eligibility, in accordance with UPM §§ 1015.10 A. and 4005.15 A.2.

   To successfully invoke Conn. Gen. Stat. § 17b-261 (h), the Conservator was required to surrender of the Policy with the insurer during the pendency of the Appellant's [redacted] 2021 Medicaid application.

6. Section 38a-457 (a) of the Connecticut General Statutes in part defines the terms "accelerated benefits of life insurance policies" and "qualifying event." Section (e) addresses the specific language and disclosures that must be in place for a life insurance policy, certificate, rider, or endorsement to pay an accelerated death benefit.

   Section 38a-457 (d)(1) of the Connecticut General Statutes addresses how insurers treat payouts of accelerated death benefits: "Death benefits may not be reduced more than the amount of the accelerated benefits paid plus any applicable actuarial discount appropriate to the policy design for policies without additional premium payments. When an accelerated benefit is paid, the amount paid may be considered as (A) a pro rata reduction in cash value or death benefits, or both, or (B) a lien against the death benefit of the contract and the access to the cash value shall be restricted to any excess of the cash value over the sum of other outstanding loans and the lien."

   It is reasonable to conclude from a strict reading of Conn. Gen. Stat. § 38a-457 (d)(1) that payout of an Accelerated Death Benefit on a life insurance policy is <u>not</u> the equivalent of the surrender of a life insurance policy. An Accelerated Death Benefit does not result in the immediate termination of the life insurance policy.

The Conservator's [redacted] 2021 petition to Colonial Penn for payment of an Accelerated Death Benefit on the Policy does not meet the criteria provided at Conn. Gen. Stat. § 17b-261 (h), as the Conservator did not initiate surrender of the Policy with the insurer.

7. "Except as provided above, the cash surrender value of life insurance policies owned by the individual is counted towards the asset limit." UPM § 4030.30 C.1. and C.2.

   For the purposes of the Medicaid program, the Policy's $1,846.74 cash surrender value was a counted asset, so long as the Conservator had not pursued surrender of the Policy with the insurer.

8. Section 17b-261 (c) of the Connecticut General Statutes provides: "For the purposes of determining eligibility for the Medicaid program, an available asset is one that is actually available to the applicant or one that the applicant has the legal right, authority or power to obtain or to have applied for the applicant's general or medical support…."

   Title 20, Section 416.1201 (a)(1) of the Code of Federal Regulations provides: "For purposes of this subpart L, resources means cash or other liquid assets or any real or personal property that an individual (or spouse, if any) owns and could convert to cash to be used for his or her support and maintenance. (1) If the individual has the right, authority or power to liquidate the property or his or her share of the property, it is considered a resource. If a property right cannot be liquidated, the property will not be considered a resource of the individual (or spouse)."

   "Subject to the conditions described in this section, equity in an asset which is inaccessible to the assistance unit is not counted as long as the asset remains inaccessible." UPM § 4015.05 A.1.

   Section 4015.05 B. of the Department's Uniform Policy Manual provides:

   Responsibilities of Assistance Unit.

   1. The burden is on the assistance unit to demonstrate that an asset is inaccessible.
   2. For all programs except Food Stamps, in order for an asset to be considered inaccessible, the assistance unit must cooperate with the Department, *as directed,* in attempting to gain access to the asset.
      a. If the unit does not cooperate as described above, the asset is considered available to the unit, and the unit's equity in the asset is counted toward the asset limit.
      b. If the unit's equity in the asset is unknown, the non-cooperative adult member of the unit is ineligible for assistance.

   UPM § 4015.05 B. (emphasis added).

   "Factors Relating to Inaccessibility. 1. The assistance unit must verify that an otherwise counted asset is inaccessible to the unit if the unit claims it can not convert the asset to cash. 2. If the unit is unable to verify that the asset is inaccessible, the asset is considered a counted asset." UPM § 4099.15 A.

The Appellant, as the owner of the Policy, had a legal right to access the cash surrender value of the Policy.

The Conservator had the legal authority to pursue the liquidation of the Policy and the responsibility to utilize the resultant funds toward the Appellant's general or medical support.

Although directed by the Department to do so, the Conservator did not attempt to access the cash value of the Policy by surrendering the Policy.

The Conservator did not meet her burden as contemplated at UPM § 4015.05 B.1. to establish that the Policy was an inaccessible asset.

The Policy's $1,846.74 cash value was an available asset, in accordance with UPM § 4015.05 B.2.a.

9. "The Department requires verification of information: a. when specifically required by federal or State law or regulations; and b. when the Department considers it necessary to corroborate an assistance unit's statements pertaining to an essential factor of eligibility." UPM § 1540.05 C.1.

   "Additional 10-day extensions for submitting verification shall be granted, as long as after each subsequent request for verification at least one item of verification is submitted by the assistance unit within each extension period." UPM § 1505.40 B. 5. b.

   "Reduction of Excess Assets. 1. The assistance unit must verify that it has properly reduced its equity in counted assets to within the program's limit. 2. If the unit does not verify that it has properly reduced its equity in counted assets, the unit is ineligible for assistance." UPM § 4099.05 B.

   The Department's [redacted] 2021 *Verification We Need* correctly gave the Conservator 10 days to submit requested documentation of the surrender of the Policy and reduction of the Appellant's assets in excess of the Medicaid program's $1,600.00 asset limit.

10. "The assistance unit must supply the Department, in an accurate and timely manner as defined by the Department, all pertinent information and verification which the Department requires to determine eligibility and calculate the amount of benefits (cross reference: 1555)." UPM § 1010.05 A.1.

    The Department correctly determined on [redacted] 2021 that the Conservator failed to verify that she had pursued the surrender of the Policy.

11. "Consequences for Failure to Provide Verification. The penalty for failure to provide required verification depends upon the nature of the factor or circumstance for which verification is required: 1. If the eligibility of the assistance unit depends directly upon a factor or circumstance for which verification is required, failure to provide verification results in ineligibility for the assistance unit. Factors on which unit eligibility depends directly include, but are not limited to: a. income amounts; b. asset amounts." UPM § 1540.05 D.1.

The Appellant was subject to the consequence for failure to provide verification of a circumstance that directly affected her eligibility to participate in the Medicaid program.

12. "The applicant's failure to provide required verification by the processing date causes: (1) one or more members of the assistance unit to be ineligible if the unverified circumstance is a condition of eligibility…." UPM § 1505.40 B.1.c.

The Department correctly determined that the Conservator had failed to submit verification that the Appellant met the financial eligibility requirements of the HUSKY-C Medicaid program by [redacted] 2021, the Department's processing date.

The Department acted in accordance with State statute and regulation when it denied the Appellant's [redacted] 2021 HUSKY-C Medicaid application on [redacted] 2021.

DISCUSSION

The Conservator cited Conn. Gen. Stat. § 17b-261 (h) and opined that her [redacted] 2021 request to Colonial Penn for payment of an Accelerated Death Benefit on the Policy prohibited the Department from denying the Appellant's [redacted] 2021 Medicaid application. The Conservator's reliance on this statute is flawed, based on a strict reading[2] of this statute.

When a life insurance policy is surrendered, the policy itself is immediately cancelled and void; the surrendered policy cannot pay a death benefit, and the surrendered policy has no equity for the insured/payor. However, per Conn. Gen. Stat. § 38a-457 (d)(1), a life insurance policy that has paid out an Accelerated Death Benefit is not surrendered to the insurer; the policy remains in the possession of the insured/payor and may pay out a pro-rated or reduced cash or death benefit.

Therefore, the conditions under which Conn. Gen. Stat. § 17b-261 (h) would trigger were not met, as the Conservator had not initiated the process to surrender the Policy with Colonial Penn during the pendency of the Appellant's [redacted] 2021 Medicaid application.

In the alternative, the Conservator cited to Section 4015.05 of the Department's Uniform Policy Manual, appearing to assert that the Policy was an inaccessible asset and as such could not be considered a counted asset during the period that it was inaccessible.

For the purposes of the Medicaid program, an asset's availability does not turn on the owner's (or his conservator's or agent's) ability to liquidate the asset. An asset's availability is tied to the owner's legal entitlement to its use for general or medical support. (See Conn. Gen. Stat. § 17b-261 (c) and 20 C.F.R. § 416.1201(a).)

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[2] "The meaning of a statute shall, in the first instance, be ascertained from the text of the statute itself and its relationship to other statutes. If, after examining such text and considering such relationship, the meaning of such text is plain and unambiguous and does not yield absurd or unworkable results, extratextual evidence of the meaning of the statute shall not be considered." Conn. Gen. Stat. § 1-2z.

The Conservator did not submit proof that the Policy was an inaccessible asset as contemplated by Conn. Gen. Stat. § 17b-261 (c) or document that Colonial Penn formally had refused to honor the contractual language of the Policy.

The Conservator instead submitted her personal invoice for billable hours related to several telephone calls. This invoice included three telephone calls the Conservator initiated with Colonial Penn following the Conservator's [redacted], 2021 submission of a claim for an Accelerated Death Benefit on the Policy: $250.00 [redacted] 2021, for .25 hours); $250.00 [redacted]/2022, for .25 hours); and $250.00 ([redacted]2022, for .25 hours). All three calls occurred *after* the Department's [redacted] 2021 denial of the Appellant's [redacted] 2021 Medicaid application.

Telephone logs documenting brief inquiries into the status of a pending claim are not sufficient to prove that the Policy was an inaccessible asset. The single-entry logs did not establish that the Appellant no longer owned the Policy or that the funds from the Policy could not be used for the Appellant's general or medical support.

The Conservator did not meet her burden in accordance with UPM § 4015.05 B.1. to prove that the Policy was an inaccessible asset.

In short, the Department informed the Conservator of what she needed to do to facilitate the Appellant's eligibility to participate in the Medicaid program. By pursuing a claim for an Accelerated Death Benefit in preference to the surrender of the Policy—against the advice of the Department—the Conservator chose a path that was unsupported by state statute and regulations governing the Medicaid program.

The Department's [redacted] 2021 denial of the Appellant's [redacted], 2021 Medicaid application is upheld.

DECISION

The Appellant's appeal is DENIED.

Eva Tar-electronic signature
Eva Tar
Hearing Officer

Cc: [redacted]
John DiLeonardo, DSS-New Haven
Rachel Anderson, DSS-New Haven
Mathew Kalarickal, DSS-New Haven
Lisa Wells, DSS-New Haven
Tonya Beckford, DSS-Willimantic

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.