

**ATTACHMENT B**  
**STAFF'S ARGUMENT**

## STAFF'S ARGUMENT TO ADOPT THE PROPOSED DECISION

Respondent Ernest A. Albertson (Respondent) enrolled in the CalPERS Long-Term Care Program (Program) in 1997. Respondent was provided with an Evidence of Coverage (EOC), which described details regarding coverage and benefits available to him under his Comprehensive Plan of Long-Term Care (Plan). Respondent continued to pay premiums and maintained coverage through 2013, when he allowed his coverage to lapse. In the summer of 2012, Respondent was diagnosed with a cancerous tumor and was hospitalized for surgery. Respondent was discharged from the hospital to his home. Respondent did not personally make a claim for benefits under his Plan. Nonetheless, a claim was submitted on his behalf. In response, Long Term Care Group, Inc. (LTCG), the third party administrator of the Program, reviewed medical records and secured an evaluation of Respondent (Benefit Eligibility Assessment or BEA) by a Registered Nurse on September 28, 2012. LTCG advised Respondent that he did not meet the EOC criteria of being "a chronically ill individual" as required in the EOC and therefore denied benefits. Respondent believed that he should be considered chronically ill and therefore sought reconsideration. LTCG denied the reconsideration. Respondent sought review by the Program, and Program staff ultimately agreed with LTCG's determination. Respondent appealed Program's determination and a hearing was held on March 25, 2015.

Prior to the hearing, CalPERS explained the hearing process to Respondent and the need to support his case with witnesses and documents. CalPERS provided Respondent with a copy of the administrative hearing process pamphlet. CalPERS answered Respondent's questions and clarified how to obtain further information on the process.

The EOC contains definitions of Activities of Daily Living (ADLs). In order to be eligible to receive benefits under the Plan, Respondent would need to have been unable to perform his ADLs in two or more of the ADL categories listed in the EOC.

**"Chronically Ill Individual** means **You** have been certified by **Licensed Health Care Practitioner** as being unable to perform (without substantial assistance from another person) at least **2 Activities of Daily Living** for at least 90 days due to a loss of functional capacity;...

**You must be a Chronically Ill Individual** to receive benefits under this coverage...."

The evidence, from medical records and Respondent's testimony, demonstrated that on July 6, 2012, Respondent went to a Kaiser emergency room with complaints of chest pain. He was evaluated, diagnosed with shingles and released. A chest x-ray was performed, which disclosed a cancerous tumor. Respondent was prescribed Coumadin, a blood thinner. Respondent remained at home – without receiving any care or treatment – until August 14, 2012, when he was admitted to a Kaiser hospital for

surgery. Respondent remained hospitalized from August 14, 2012 through August 24, 2012. On August 24, 2012, Respondent was discharged to his home, with Kaiser providing him with follow-up care through a home health agency. On September 11, 2012, the home health agency advised Respondent that he would not receive any further visits after September 13, 2012.

Respondent's claim is that he was chronically ill from the date of the initial diagnosis and prescribing of Coumadin on July 6, 2012, through to December 12, 2012, when he was taken off Coumadin. However, Respondent did not submit any evidence, whether medical records or testimony, from a licensed care practitioner to demonstrate that he was unable to perform, without assistance, at least two of the ADLs listed in the EOC. After the initial claim for benefits was made on Respondent's behalf (which Respondent assumes was made by his cousin, who was assisting him after his August 2012 surgery), Respondent did not provide to LTCG, Program staff, or at the hearing, copies of any bills indicating that he had received and/or paid for any care or services provided by a third party during either the period before his surgery (July 6, 2012 to August 14, 2012) or the period following his surgery (August 25, 2012 to December 12, 2012).

Program witnesses testified at the hearing and applicable documents, including the EOC, were introduced into evidence. The witnesses explained that the medical records demonstrated that Respondent did not have any limitations in activities of daily living between July 6, 2012 and August 24, 2012. Once discharged from the hospital, the records showed that Respondent did need assistance, which he received through the home health agency arranged for and paid by Kaiser, Respondent's health care provider. The need for such services ceased by September 13, 2012. The witnesses also explained the 90-day deductible period included in the provisions of the Plan. The 90-day deductible period was modified in 2000 as a result of requirements contained in the Health Information Portability and Accountability Act (HIPPA).

After considering all of the evidence, the Administrative Law Judge (ALJ) found that Respondent could be considered to have been chronically ill between August 12, 2012 and August 24, 2012 (13 days) and from August 25, 2012 to September 11, 2012 (18 days), for a total of 31 days. Accordingly, the ALJ found that Respondent can be "credited" with a total of 31 days toward meeting the 90-day deductible period under the Plan. However, the services provided to Respondent during these 31 days were provided through Respondent's health care coverage with Kaiser. There is no claim by Respondent that the Program pay for or somehow reimburse him for the cost of such services, or that he had been made responsible for any costs.

The ALJ also found that Respondent, even under the most generous interpretation, did not demonstrate that he met the applicable 90-day deductible period under the Plan. Therefore, although Respondent was entitled to 31 days credit, that credit was insufficient to complete the deductible period. Accordingly, the ALJ found that Respondent was not and would not be entitled to receive any benefits under the Plan.

The ALJ concluded that Respondent's appeal should be denied as to entitlement to any benefits due from CalPERS. The Proposed Decision is supported by the law and the facts. Staff argues that the Board adopt the Proposed Decision. The Board is reminded that there is no active long-term care coverage available to Respondent through the program, since Respondent ceased paying premiums in 2013 and let his coverage lapse.

Because the Proposed Decision applies the law to the salient facts of this case, the risks of adopting the Proposed Decision are minimal. The member may file a Writ Petition in Superior Court seeking to overturn the Decision of the Board.

June 17, 2015



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