ATTACHMENT A

THE PROPOSED DECISION

BEFORE THE
BOARD OF ADMINISTRATION
CALIFORNIA PUBLIC EMPLOYEES' RETIREMENT SYSTEM
STATE OF CALIFORNIA

In the Matter of the Statement of Issues Against:	Case No. 2014-0179
ERNEST A. ALBERTSON,	OAH No. 2014080679
Respondent.	

PROPOSED DECISION

This matter was heard by David B. Rosenman, Administrative Law Judge, Office of Administrative Hearings (OAH), on March 25, 2015, in Los Angeles, California.

Rory Coffey, Senior Staff Counsel, represented the California Public Employees' Retirement System (PERS). Ernest A. Anderson (respondent) was present and represented himself.

The Statement of Issues was amended twice during the hearing. A typographical error was corrected at page 8, line 1, to change "2013" to "2012." A written amendment to the Statement of Issues was submitted and marked for identification as exhibit 17.

An oral Protective Order was issued on the record to protect confidential information. Some exhibits were redacted and the following exhibits are sealed: 3, 4, 6, 7, 8, 9, 11, 12 and 13. A written Protective Order will be issued and served.

Oral and documentary evidence was received. The record was closed and the matter was submitted for decision on March 25, 2015.

ISSUES

1. Whether respondent is eligible for benefits from his PERS Long-Term Care Program under a claim covering the period August 25, 2012 through November 1, 2012.

2. Whether respondent met some or all of the 90-day deductible period regarding a claim covering the period August 25, 2012 through November 1, 2012.[1]

FACTUAL FINDINGS

1. Kathleen Donesson made and filed the Statement of Issues in her official capacity as the Chief of the Health Plan Administration Division of PERS. Rory Coffey made and filed the amendment to the Statement of Issues in his official capacity as counsel for PERS.

2. Respondent became covered under the PERS Long-Term Care Program (LTC Program) as of September 1, 1997. His coverage was continually in effect until sometime in 2013, after the claim at issue in this case.

3. The LTC Program is authorized under the Long-Term Care Act found in Government Code sections 21660 to 21664. The PERS Board of Administration maintains the LTC Program, which is a self-funded plan. The Long-Term Care Group, Inc. administers the LTC Program for the Board.

4. The terms of the LTC Program are in an Evidence of Coverage booklet (EOC). (Exhibit 13.) Some terms of the EOC that apply to this matter include:

"**Activities of Daily Living** means the following self-care functions:

"**Bathing**: Cleaning the body using a tub, shower or sponge bath, including getting a basin of water, managing faucets, getting in and out of tub or shower, reaching head and body parts for soaping, rinsing, and drying.

"**Dressing**: Putting on and taking off, fastening and unfastening garments and undergarments, and special devices such as back or leg braces, corsets, elastic stockings/garments and artificial limbs or splints.

"**Toileting**: Getting on and off a toilet or commode and emptying a commode; managing clothes and wiping and cleaning the body after toileting, and using and emptying a bedpan and urinal.

"**Transferring**: Moving from one sitting or lying position to another sitting or lying position (e.g., from bed to or from a wheelchair or sofa), coming to a standing position, and/or repositioning to promote circulation and prevent skin breakdown.

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[1] This issue was added in the written amendment to the Statement of Issues, exhibit 17.

"**Continence**: Ability to control bowel and bladder as well as use ostomy and/or catheter receptacles; and apply diapers and disposable barrier pads.

"**Eating**: Reaching for, picking up, grasping a utensil and cup; getting food on a utensil, bringing food, utensil, and cup to mouth; manipulating food on plate; and cleaning face and hands as necessary following meal."
(Exhibit 13, p. 3; emphasis in original.)

"**Assessment** means an evaluation done by **Us** or **Our** representative to determine or verify **Your** deficiencies in **Activities of Daily Living** or **Your** severe **Cognitive Impairment**. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results." [¶] . . . [¶]

"**Chronically Ill Individual** means **You** have been certified by a **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; or **You** require substantial supervision to protect **You** from threats to **Your** health and safety due to severe **Cognitive Impairment**."
(Exhibit 13, p. 4; emphasis in original.)

"CONDITIONS FOR RECEIVING BENEFITS

"This section describes important features of **Your** coverage and how **You** become eligible to receive benefits. **You** must be a **Chronically Ill Individual** to receive benefits under this coverage and meet all of the Conditions for Receiving Benefits as described in this section.

"**All Other Benefits**

"**We** will pay all other benefits when **We** determine that **You**:
"· Cannot perform two (2) or more of the **Activities of Daily Living** without substantial human assistance; or
"· Require substantial supervision to protect yourself from threats of **Your** health and safety due to severe **Cognitive Impairment**; or
"· Incur covered expenses; and
"· Meet the Additional Requirements for Receiving Benefits outlined below.

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"**Additional Requirements for Receiving Benefits**

"**We** will pay the benefits described in this **Agreement** when the following requirements are met:

"· the coverage is in force on the date(s) the care is approved and received;

"· the service is covered under this **Agreement** and provided pursuant to a **Plan of Care**;

"· **You** have completed the **Deductible Period** that applies. . . ."
(Exhibit 13, p. 8; emphasis in original.)

5. As relevant to this matter, under the terms and conditions noted above, respondent could receive benefits if a licensed health care professional determined he was unable, or needed substantial assistance from another person, to perform at least two of the listed Activities of Daily living, after respondent met the 90-day deductible period.

6. The deductible period defined in the EOC was replaced by a Comprehensive Plan Rider in 2000. The Comprehensive Plan Rider is also in exhibit 13 and states, in pertinent part: "**Deductible Period** (also called an Elimination Period) means the total number of calendar days that must elapse before the benefits covered by this **Agreement** are payable. The **Deductible Period** begins on the first day **You** receive **covered Formal Long-Term Care Services** after **You** have become eligible for benefits and have met the Conditions for Receiving Benefits. **You** are not required to continue to receive covered services to satisfy the **Deductible Period**, but **You** must continue to be eligible for benefits and to meet the Conditions for Receiving Benefits for the number of days shown on the Schedule of Benefits in order to satisfy the **Deductible Period**. The number of days required to satisfy this **Deductible Period** do not need to be consecutive as long as they are accumulated within a 12 consecutive month period after **You** have met the Conditions for Receiving Benefits.

"The number of days may be accumulated before the filing of a claim if **We** establish that **You** met the requirements outlined above before filing a claim. . . ."
(Exhibit 13; ; emphasis in original.)

7. On or around September 21, 2012, a claim was submitted on respondent's behalf requesting benefits from the LTD Program for the period August 25, 2012 to November 1, 2012. Although respondent does not recall submitting the claim, he authorized his cousin to help him with paperwork and claims while he was ill. Although PERS does not have a copy of the claim, it will accept claims made by telephone. Even without documentary evidence of the actual claim, it is presumed that PERS acted properly when it began processing the claim. Respondent has acted subsequently as if the claim had in fact been submitted on his behalf.

8. Long Term Care Group, Inc. reviewed medical records, home therapy notes and a Benefit Eligibility Assessment dated September 28, 2012. Long Term Care Group, Inc. determined that respondent was not a "Chronically Ill Individual" as defined in the EOB

and therefore not eligible for benefits for the requested period. Long Term Care Group, Inc. notified respondent of the denial by letter dated November 6, 2012. The letter also notified respondent of his right to request reconsideration.

9. Respondent requested reconsideration of the denial by letter dated November 14, 2012. He also asked whether any part of his 90-day deductible period had been satisfied. After a review of additional information, Long Term Care Group, Inc. upheld the denial of benefits and informed respondent by letter dated December 31, 2012. This letter does not address the deductible issue. Respondent was also informed of his right to appeal this determination to the Program.

10. Respondent submitted his appeal to the Long Term Care Group, Inc. by letter dated January 9, 2013, which was forwarded to the LTC Program for review.

11. The LTC Program performed a review and determined that respondent was not eligible for benefits from August 25, 2012 through November 1, 2012. The LTC Program notified respondent of the denial by letter dated May 24, 2013. The letter also stated that respondent had not met the deductible period. Respondent was also notified of his right to request an administrative hearing.

12. Respondent submitted his appeal by letter dated June 24, 2013, and requested an administrative hearing.

13. Additional information was provided about the course of respondent's illnesses and treatments, and his condition at various relevant times, the relevant parts of which are summarized as follows. Respondent had been diagnosed with diabetes. On July 6, 2012, he experienced debilitating chest pain and went to the Kaiser emergency room. He was diagnosed with shingles and treated for pain. A chest x-ray also revealed a cancerous tumor on his right kidney. Respondent was prescribed Coumadin, a blood thinner. Respondent considered himself to be chronically ill as of these findings and prescription. He saw a surgeon August 27, and the formal diagnosis of kidney cancer was made. Respondent stated that he was home, and largely confined to bed, from July 6 until surgery on August 14, 2012, to remove the tumor and a portion of his kidney. Respondent was hospitalized until August 24, 2012. During the hospitalization, respondent developed two blood clots, which were treated successfully. Respondent told a discharge planner that he wanted to go to a facility for care; however, he was discharged to his home. Respondent complained to Kaiser and to PERS about the nature of his nursing care while in the hospital as well as the process of his discharge. For a time it was thought there was also a tumor on his left kidney; however, this was later diagnosed as a cyst.

14. After respondent was discharged to his home on August 24, 2012, a home health agency paid by Kaiser provided limited care and physical therapy on a few occasions, including taking vital signs and some pictures. On September 11, 2012, the home health agency told respondent he would receive no further visits as of September 13. On September 28, 2012, respondent was visited by Linda Cartwright, R.N., who did not do a physical

examination or take any vital signs. She spoke with respondent, asking questions to assess his mental competency. This visit is described as a Benefit Eligibility Assessment. The home health notes and written Benefit Eligibility Assessment were not submitted as evidence at the hearing. However, they were reviewed and relied upon by Kathy Donneson and Nandini Narayan, M.D., as described below.

15. Specific reasons for denial of respondent's claim are found in a letter from Donneson, Chief of PERS' Health Plan Administration Division, and testimony from Narayan, M.D. In her letter dated May 24, 2013, Donneson notes that physical therapy was provided by Kaiser from August 25 through September 11, 2012, so this period was not being considered in the appeal. Donneson writes that, from September 12 through November 1, 2012, respondent needed assistance with only one activity of daily living, mobility.[2] (The source of this information is not referenced.) As there was no other activity requiring assistance, Donneson concluded respondent did not meet the definition of being chronically ill. (Exhibit 8.)

16. With regard to the deductible, Donneson notes: there was no documentation of limitations in any activities of daily living for the period July 6 through August 24, 2012; the home health notes indicated respondent needed assistance with bathing, dressing, toileting and transferring as of August 25, and as of his discharge from home health on September 13, he needed only intermittent assistance with bathing and was independent with all other activities; and the Benefit Eligibility Assessment on September 28, 2012, indicated he was independent with all activities of daily living except for mobility. (Exhibit 8.) The evidence supports the circumstances as described in Donnesons's letter.

17. Demmis Devore has been employed by PERS since July 7, 2013, and is a Health Program Manager II. Devore reviewed respondent's case file. Devore explained that once a beneficiary has been chronically ill for 90 days, the required deductible period is over and the beneficiary can begin to receive benefits. The benefits are not retroactive to the beginning of the 90 days; rather, the benefits would start at day 91 of a chronic illness. It is a lifetime deductible because once it is met, a beneficiary does not have to meet any other deductible period. If a beneficiary meets the lifetime deductible and has a later period of chronic illness, benefits can start immediately. Due to the federal Health Information Portability and Accountability Act (HIPAA), the deductible period was amended, effective in 2000, to require the 90-day period to accrue within a 12-month period. According to Devore, respondent's hospitalization from August 12 to August 24, 2012, would count towards his 90-day deductible period.

18. Dr. Narayan has been employed by PERS as a medical consultant since June 2014. She reviewed the file to prepare for testimony at the hearing. In Dr. Narayan's opinion, respondent was chronically ill, as defined in the EOB, for only the period of 18 days after his discharge (August 25 through September 11, 2012), when the home health agency

[2] Of note, "mobility" is not one of the Activities of Daily Living listed in the EOC booklet, exhibit 13.

did its last visit and informed respondent he would no longer receive home services. As of this date, respondent did not need assistance in at least two activities of daily living. She added that the period of chronic illness could also include the days respondent was in the hospital. The evidence supports the circumstances as described in Dr. Narayan's testimony.

19. Therefore, respondent is entitled to "credit" of 31 days towards meeting his 90-day deductible. This consists of 13 days (August 12 to 24, 2012) as noted by Devore, and 18 days (August 25 to September 11, 2012) as noted by Dr. Narayan.

20. Respondent contends that he was chronically ill and, therefore, entitled to credit towards the deductible, from the initial diagnoses and prescribing of Coumadin on July 6, 2012, until he was taken off of Coumadin on December 12, 2012. Respondent did not submit any evidence from a licensed health care practitioner to establish that he was unable to perform, either entirely or without substantial assistance from another person, at least two of the Activities of Daily Living as defined in the EOB. Respondent argues that it is inconsistent for PERS to rely upon evidence that he still needed partial assistance with bathing as of his discharge from home health services and not also conclude that he needed assistance with dressing. However, respondent did not submit any documents indicating he had any limitations in his Activities of Daily Living. Respondent did not submit any bills to PERS, or at the hearing, indicating he received and paid for any care provided by a third party for the periods when he claims he was chronically ill; that is, from July 6 through August 14, 2012, and again from August 25 through December 12, 2012, when he was taken off Coumadin.

21. Respondent was limited in his activities during the period of his illnesses. He stated, without contradiction, that he was largely bedridden after returning from the emergency room visit and had limited activities after returning home following his surgery. However, respondent's condition must meet the definition of chronic illness under the LTC Program for him to receive credit towards the 90-day deductible period and, thereafter, to receive benefits. The totality of the evidence establishes that respondent met the requirements of the LTC Program for the 31 days referenced in Fact Finding 19. He is entitled to "credit" for those 31 days towards the 90 days in the required deductible period. He did not establish that he met the limitations in Activities of Daily Living for any other time periods by virtue of an opinion from a licensed health care provider, as required under the LTC Program. Because he did not meet the entire deductible period, respondent is not entitled to any benefits from the LTC Program for the period of his claim from August 25 to November 1, 2012.

LEGAL CONCLUSIONS

1. When reviewing the denial of an application for benefits, the burden of proof is on the applicant. (*Lindsay v. San Diego Retirement Bd.* (1964) 231 Cal.App.2d 156, 161 (disability benefits); *Greatorex v. Board of Admin.* (1979) 91 Cal.App.3d 54, 57 (retirement benefits).) Here, the burden of proof is on the respondent.

2. The LTC Program is authorized under Government Code section 21661, which includes: "(h) The board shall establish eligibility criteria for enrollment, establish appropriate underwriting criteria for potential enrollees, define the scope of covered benefits, define the criteria to receive benefits, and set any other standards as needed. . . ."

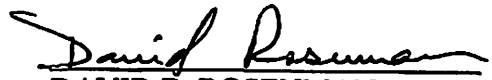
3. Government Code section 21664 provides, in pertinent part, that the Public Employees' Long-term Care Fund is established "for the purpose of administering any self-funded long-term care plan developed by the board"; the board may set premiums and shall have the exclusive control of the administration and investment of the Public Employees' Long-term Care Fund; and the Public Employees' Long-term Care Fund is a trust fund held for the exclusive benefit of enrollees in the long-term care plans.

4. As set forth in Fact Findings 4 through 21, respondent is entitled to "credit" for 31 days towards the 90 days in the required deductible period. Respondent is not entitled to any benefits from the LTC Program.

ORDER

The appeal of respondent Ernest A. Albertson of the decision by the Board of Administration, California Public Employees' Retirement System, is granted in part and denied in part. Respondent is entitled to "credit" for 31 days towards the 90 days in the required deductible period. Respondent is not entitled to any benefits from the LTC Program.

Dated: April 17, 2015.



DAVID B. ROSENMAN
Administrative Law Judge
Office of Administrative Hearings