DOCKET NO. HHB-CV-21-6066041	:	**SUPERIOR COURT**
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ANTHONY LORUSSO, ADMINISTRATOR OF THE ESTATE OF JOSEPHINE LORUSSO	:	**JUDICIAL DISTRICT OF NEW BRITAIN**
	:	
VS.	:	**ADMINISTRATIVE APPEALS**
	:	
COMMISSIONER OF THE DEPARTMENT OF SOCIAL SERVICES	:	**JULY 25, 2022**

MEMORANDUM OF DECISION

INTRODUCTION:

This matter is an administrative appeal of a final decision of the Commissioner (Commissioner) of the Department of Social Services (DSS), through her hearing officer, in a March 12, 2021 final decision (the "Final Decision") denying long-term care Medicaid benefits for Josephine LoRusso (applicant). Anthony LoRusso as administrator of the estate of Josephine LoRusso (plaintiff), has brought this administrative appeal challenging the Final Decision.

FACTS AND PROCEDURAL HISTORY:

The following facts are relevant to a decision in this appeal and are contained in the record. The plaintiff, on behalf of the applicant, who was then a resident in a rehabilitation facility, filed an application with DSS for long-term care Medicaid benefits on March 6, 2020.

Electronic notice sent to all counsel of record.
Sent to official reporter. A. Jordanopoulos,
7-25-22

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As of March 6, 2020, the applicant's son[1] and daughter had power of attorney authority to act on behalf of the applicant. Beginning on March 9, 2020, DSS informed the plaintiff that the applicant's assets exceeded the $1,600 asset eligibility limit for Medicaid benefits and requested proof of the cash surrender value of a life insurance policy. On March 26, April 30, June 29, and July 16 of 2020, DSS again requested proof of the cash surrender value of a Banker's Life Insurance Policy on the life of the applicant. On August 9, 2020, DSS received a copy of the Banker's Life Insurance Policy with a face value of $10,000, along with a letter from the insurance company indicating that the current cash surrender value of the policy was $6,160.80. On August 10, 2020, DSS informed the plaintiff that the cash surrender value of the policy was countable in the applicant's assets and exceeded the asset eligibility limit for Medicaid benefits. On August 10, 2020, the plaintiff asked DSS for advice on how he could obtain and spend down the cash surrender value of the life insurance policy. It was necessary to obtain signatures of three siblings, including the plaintiff, to surrender the policy. On September 2, 2020, DSS denied Medicaid benefits to the applicant because her assets exceeded the Medicaid asset eligibility limit, primarily due to the cash surrender value of the life insurance policy. On September 7, 2020, the applicant died. The life insurance policy was not surrendered before the applicant died. The plaintiff requested a hearing to challenge DSS' denial of benefits. Subsequent to the

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[1] The plaintiff.

applicant's death, the plaintiff collected $10,000 on the applicant's life insurance policy and provided the life insurance proceeds to the rehabilitation facility in partial payment of the applicant's outstanding bill.

On January 6, 2021, a hearing was held before a hearing officer in the Office of Legal Counsel, Regulations and Administrative Hearings (OLCRAH). The hearing officer kept the hearing open to receive additional evidence which was submitted to the hearing officer by the applicant's attorney in an e-mail on January 19, 2021, namely, copies of (i) an unsigned form entitled Request to Surrender for Net Cash Value dated August 28, 2020, and (ii) a Banker's Life and Casualty Company's Annuity Death Benefit Claim Form which was signed by the plaintiff and dated October 12, 2020. The hearing officer then issued her Final Decision on March 12, 2021, denying the applicant's application for long-term care Medicaid benefits. On or about May 19, 2021, the plaintiff appealed the Final Decision to this court.

The plaintiff, as administrator of the applicant's estate, is aggrieved because he appeals a final adverse decision of the OLCRAH hearing officer affirming DDS' denial of long-term care Medicaid benefits for the applicant.

STANDARD OF REVIEW:

This appeal is brought pursuant to the Uniform Administrative Procedure Act (UAPA), General Statutes § 4-183.[2] Judicial review of an administrative decision in an appeal under the UAPA is limited. *Murphy* v. *Commissioner of Motor Vehicles*, 254 Conn. 333, 343, 757 A.2d 561 (2000). "[R]eview of an administrative agency decision requires a court to determine whether there is substantial evidence in the administrative record to support the agency's findings of basic fact and whether the conclusions drawn from those facts are reasonable. . . . Neither [the Supreme Court] nor the trial court may retry the case or substitute its own judgment for that of the administrative agency on the weight of the evidence or questions of fact. . . . Our ultimate duty is to determine, in view of all of the evidence, whether the agency, in issuing its order, acted unreasonably, arbitrarily, illegally or in abuse of its discretion." (Internal quotation marks omitted.) Id.

Although the courts ordinarily afford deference to the construction of a statute applied by the administrative agency empowered by law to carry out the statute's purposes, "[c]ases that

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[2] Section 4-183 (j) provides in relevant part: "The court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. The court shall affirm the decision of the agency unless the court finds that substantial rights of the person appealing have been prejudiced because the administrative findings, inferences, conclusions, or decisions are: (1) In violation of constitutional or statutory provisions; (2) in excess of the statutory authority of the agency; (3) made upon unlawful procedure; (4) affected by other error of law; (5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or (6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. If the court finds such prejudice, it shall sustain the appeal and, if appropriate, may render a judgment under subsection (k) of this section or remand the case for further proceedings. . . ."

present pure questions of law . . . invoke a broader standard of review than is . . . involved in deciding whether, in light of the evidence, the agency has acted unreasonably, arbitrarily, illegally or in abuse of its discretion." (Internal quotation marks omitted.) *Dept. of Public Safety* v. *Freedom of Information Commission*, 298 Conn. 703, 716, 6 A.3d 763 (2010).

ANALYSIS:

Medicaid Title XIX is a social benefit program intended to be used by people who are incapable of caring for themselves and do not have the resources to pay for the care they need. To meet these goals, Congress enacted provisions designed to assure that only persons who are in fact poor and have not transferred assets that could have been used to pay for needed services are provided the program's benefits. Medicaid eligibility determinations consider both income and assets. In general, an applicant may not have more than $1,600 in available assets in order to be eligible for Medicaid benefits.[3] Eligibility for Medicaid benefits can only be confirmed when the applicant's applicable assets do not exceed the prescribed limit.

Under the applicable definitions, a resource is an asset (i) owned by the plaintiff, (ii) which can be converted to cash for use in supporting the plaintiff, and (iii) which the plaintiff is

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[3] Medicaid benefits may only be provided if the applicant's available income and assets are below the prescribed eligibility limits. See General Statutes § 17b-80 (a). The relevant Medicaid asset limit is $1,600. See Dept. of Social Services, Uniform Policy Manual § 4005.10 (A) (2) (a).

not legally restricted from using. See Dept. of Social Services, Uniform Policy Manual § 4015.05P (UPM § 4015.05P).[4] Connecticut law provides that even if the foregoing three points are found, the plaintiff can still avoid having the asset counted against him if the plaintiff can prove that the asset was inaccessible. Thus, Connecticut law is more favorable to the plaintiff because it provides an additional opportunity beyond the basic definition of a resource to avoid an asset being counted.

General Statutes § 17b-261 (c) provides in relevant part as follows:

> "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. . . ." (Emphasis added.)

Thus, in order for an asset to be counted in an eligibility determination it must be "actually available" or the applicant must have the power "to obtain" it. These concepts are similar and look not solely to the legal title to the asset, but to the applicant's actual ability to get his hands on the asset (i.e., its actual availability to him or his power to obtain it). The provisions of UPM § 4015.05P dealing with the concept of inaccessibility consider the opposite side of the coin from the foregoing statute and place the burden of proof on the applicant. Applicants for Medicaid

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[4] Legal restrictions can arise from things such as (i) an encumbrance or lien, (ii) joint owners of an account, or (iii) fiduciary obligations or trust terms associated with an account. In cases where a spouse remains in the community, specified regulatory consideration is given to an amount that is separately retainable by the spouse.

benefits bear the burden of establishing their eligibility, and must timely and accurately provide DSS with the information necessary to meet the applicant's burden. See Dept. of Social Services, Uniform Policy Manual § 1010.05 (A) (1). See also *Harrison* v. *Commissioner*, 204 Conn. 672, 679, 529 A.2d 188 (1987).

In this matter, at all times relevant to this appeal, the applicant owned a Banker's Life Insurance policy that had a face value of $10,000, and a current cash surrender value of $6,160.80. The policy insured the life of the applicant. The hearing officer found, and substantial evidence in the record supports a finding, that the life insurance policy was a resource of the applicant with an asset value of $6,160.80, and the plaintiff has not argued otherwise. Further, the cash surrender value of the policy was the amount included as a resource/asset of the applicant. The cash surrender value of the policy was available to the plaintiff. [5] Accordingly, for the period from the date of the applicant's application for Medicaid benefits through the date of DSS' denial of Medicaid benefits, the applicant had assets that exceeded the Medicare eligibility limit. As a result, the hearing officer concluded that DSS properly denied Medicaid benefits to the applicant on September 2, 2020.

The plaintiff presents two challenges to the hearing officer's decision on appeal. First, the plaintiff asserts that the hearing officer was unfairly influenced by an e-mail by the DSS

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[5] At all times relevant, the plaintiff had the authority, through a power of attorney, to surrender the life insurance policy and obtain the cash surrender value thereof.

caseworker without an opportunity for cross-examination. Second, the plaintiff asserts that the plaintiff was "pursuing surrender" of the life insurance policy and, accordingly, the policy should not be used to deny Medicaid benefits pursuant to the provisions of General Statutes § 17b-261 (h).[6]

Cross-Examination

As noted, the plaintiff asserts that the hearing officer was unduly prejudiced by an e-mail by the caseworker without an opportunity for the plaintiff to cross-examine. The situation that the plaintiff refers to arises out of the fact that the hearing officer left the hearing open for two weeks in order to receive into evidence a document[7] that the plaintiff discussed in his testimony but did not produce. The plaintiff's attorney produced this document, along with another document, to the hearing officer in an email, which email copied the DSS caseworker. The plaintiff asserts that the DSS caseworker then "replied to all" and asked the following two questions in an email: (i) "Do you have confirmation from bankers life of submission or communication from them?" and (ii) "It's my understanding from the hearing officer that he started completing the paperwork when it was sent to him but it was never filed with the

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[6] The plaintiff repeatedly misquotes the statutory section reference of the statutory provision that the plaintiff intends to assert as General Statutes § 17b-261 (f) in his brief.

[7] The Request to Surrender for Net Cash Value dated August 28, 2020. The plaintiff had testified that he received this document from the life insurance company but never completed it nor submitted it back to the company. See record page 140, line 15 to record page 141, line 10.

company until after the client's death correct?"[8] The plaintiff contends that the foregoing two questions, presented by an email in response to his email, amounted to testimony by the caseworker which was not subject to the plaintiff's cross examination. The plaintiff does not argue that the second question was prejudicial.[9] The plaintiff contends that the first question was entered into evidence over the plaintiff's objection and casts doubt on the plaintiff's testimony concerning this document by insinuating that his testimony should not be trusted without confirmation from the life insurance company. The plaintiff's arguments in this regard are misplaced for several reasons.

First, it was agreed by the hearing officer and the parties that the record would be left open for two weeks so that the plaintiff could submit the Request to Surrender for Net Cash Value dated August 28, 2020. See record at page 140, line 15 to page 141, line 10. As expected, the plaintiff submitted the document. Although the hearing officer may have seen the caseworker's email questions, there is no evidence or indication in her decision that she either considered the question to be evidence or that it factored into her decision.[10]

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[8] As evidence of this, the plaintiff references record pages 160, 162, and 164.

[9] In the plaintiff's brief, the plaintiff states that the record contains substantial evidence which is consistent with the information contained in the second question. See, e.g., record page 141, line 12 to record page 142, line 16.

[10] At the plaintiff's objection, the hearing officer directed that the email questions would be stricken from the record, indicating her intention not to consider them. The emails were later added back to the record in this appeal at the request of the plaintiff.

Second, the question posed by the caseworker was just that: a question. In particular, the first question is solely a question and does not declare any information. Further, the plaintiff's testimony was clear that he did not submit the completed form to the life insurance company before the applicant's death. See record page 141, line 12 to page 142, line 16. Accordingly, asking whether the plaintiff had confirmation from the life insurance company regarding the form could not have prejudiced the plaintiff, because he readily admitted that he had not filed the form.

Lastly, in view of the foregoing, it cannot be reasonably concluded that the lack of cross-examination concerning these email questions produced substantial prejudice to the plaintiff. The hearing officer indicated that she would not consider the questions[11], and the two communications were just that: questions, not declarations or commentary. See *Ann Howard's Apricots Restaurant, Inc.* v. *Commission on Human Rights and Opportunities*, 237 Conn. 209, 227–28, 676 A.2d 844 (1996).

In view of the foregoing, the court finds that the plaintiff was not substantially prejudiced by the e-mail in question.

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[11] The plaintiff has presented no reason to doubt the hearing officer's representation that she would not consider the e-mail questions. She struck them from the record. This e-mail was added back into the record later in this appeal at the request of the plaintiff's attorney.

General Statutes § 17b-261 (h)

The plaintiff asserts that the provisions of General Statutes § 17b-261 (h) should have precluded DSS from denying Medicaid benefits based upon the value of the life insurance policy because the plaintiff was pursuing surrender of the policy. Section 17b-261 (h) provides: "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." (Emphasis added.) By its clear terms, the foregoing statute applies to life insurance policies "worth less than ten thousand dollars". The policy in this case was a $10,000 policy, and, accordingly, it was not worth **less than** $10,000. The court notes that the statute separately refers to the "cash value" of the policy, which the court interprets as the cash surrender value of the policy, and the "worth" of the policy, which the court interprets as the face value of the policy. The foregoing interpretation is supported by the fact that our legislature used two different terms in a single sentence, "cash value" and "worth", indicating that the two different terms have separate meanings. Accordingly, § 17b-261(h) does not apply to the life insurance policy or the situation at hand.

Further, the hearing officer determined as a factual matter that the plaintiff had not provided sufficient evidence that he was pursuing the surrender of the policy. See section eight of the Final Decision's conclusions of law. Accordingly, the hearing officer found that the plaintiff failed to prove that he was pursuing surrender of the policy. The hearing officer was the

finder of fact and had the right to credit, discredit, and weigh the evidence. As a result, the hearing officer's finding that the plaintiff failed to prove that he was pursuing surrender of the policy will stand as long as the record contains substantial evidence to support it. The court finds that the record contains substantial evidence to support the hearing officer's conclusion, including: (i) the fact that the application for Medicaid benefits remained pending from March 6, 2020 until September 2, 2020, giving the plaintiff time to resolve the applicant's assets, and during the foregoing period, the plaintiff had power of attorney for the applicant authorizing him to act for her, (ii) DSS quickly and repeatedly warned the plaintiff that the applicant was over the asset eligibility limit due to the life insurance policy, which needed to be surrendered and the resulting cash appropriately spent down, (iii) during the entire pendency of the application, the plaintiff failed to surrender the policy, (iv) finding of fact 21 notes that the surrender form remained unsigned even at that late date, (v) the plaintiff testified that he never submitted the surrender form to the insurance company, and did not submit any form to the insurance company until after the applicant's death, and (vi) it was the applicant's and the plaintiff's responsibility to establish eligibility for the Medicaid benefits. In view of the foregoing, it was not error for the hearing officer to conclude that the plaintiff failed to prove that he was in the process of surrendering the policy.[12]

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[12] This remains true even if the record contains countervailing evidence that could support another conclusion. Further, it was the plaintiff's burden to prove that he was "pursuing" surrender of the policy in a timely manner. In

Conclusion

The court finds that, on appeal, the plaintiff has failed to establish that the hearing officer's Final Decision was (1) in violation of constitutional or statutory provisions; (2) in excess of the statutory authority of the agency; (3) made upon unlawful procedure; (4) affected by other error of law; (5) clearly erroneous in view of the reliable, probative, and substantial evidence on the whole record; or (6) arbitrary or capricious or characterized by abuse of discretion or clearly unwarranted exercise of discretion. Accordingly, the court must respectfully dismiss the appeal.

ORDER:

The appeal is dismissed.

John L. Cordani, Judge

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view of the evidence, it was not unreasonable for the hearing officer to find that the plaintiff failed to meet his burden.