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Connecticut's "State Supp" (AABD) Benefit

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What is now referred to as "State Supp.," or "aid to the aged, blind, and disabled" (AABD) has its origins in state welfare programs that pre-date Medicaid. In 1972, with the creation of a new federally administered program for cash assistance known as "SSI," these programs were fused and converted to a program that would only "supplement" the new federal benefit. Technically titled "Optional State Supplementation," Conn. Gen. Stat. § 17b-600, the benefit became known as "State Supplement" and has been shortened to "State Supp." In the Department of Social Services Uniform Policy Manual, however, it is referenced as "AABD," and the terms "State Supp." and "AABD" are used interchangeably throughout this article.

The new "supplemental" program, even though supported by State funds, still had to meet certain federal requirements, but these requirements are not identical to the requirements of the Medicaid program—while a recipient of AABD is automatically qualified for Medicaid, the reverse is not the case. AABD has certain significant differences, notably with regard to amount of benefit, start date, lack of spousal protections, liens, and transfer penalties. These differences can be confusing to practitioners **and** consumers, particularly when a facility incorrectly identifies the source of payment as "Medicaid" when it is actually AABD. It is important for the practitioner to keep in mind that AABD is a cash assistance program, not a medical assistance program, and that it is funded entirely from State sources, not federal. This chapter will review the origins of AABD and its interaction with the SSI benefit, and will then detail the rules that govern AABD eligibility and the computation of benefit.

Background

Pre-SSI Benefits

Prior to the enactment of major Social Security Act provisions in 1972, many states administered “adult welfare programs” known as “Aid to the Permanent and Totally Disabled” or “APTD.” States made their own disability determinations. (In Connecticut, the “medical review team” made the determinations.) By 1972, these programs were funded at least in part by federal grants to the states for aiding the needy aged, blind, and disabled, under Titles XIV (disabled) and X (blind) of the Social Security Act.¹ Connecticut’s adult welfare statute, now Conn. Gen. Stat. § 17b-600, was originally enacted in 1949, as 1949 Rev., S. 2866. By 1972, Connecticut had three statewide welfare programs of this kind: (1) Old Age Assistance (OAA), (2) Aid to the Blind (AB), and (3) Aid to the Disabled (AD).² Each program had its own “standards of assistance” for many different needs—each person’s “budget” could be different.

Enactment of SSI

In 1972, Congress created Title XVI of the Social Security Act by adopting Public Law 92-603. Title XVI created the Supplemental Security Income Benefit for those who were financially eligible and met the criteria of being “aged” (over 65), or blind, or “disabled,” i.e., meeting the now-familiar Social Security disability standard: “any person unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment expected to result in death or that has lasted or can be expected to last for a continuous period of at least 12 months,” except that for a child under age 18, “eligibility is based on disability of severity comparable with that of an adult.” However, Public Law 92-603 grandfathered in those receiving APTD benefits based on state-determined criteria for blindness and/or disability.³ Revisions to the law required that starting July 1973, recipients would have to meet the federal criteria for blindness and disability; starting in 1974, the federal grants (originally under Titles X and XIV and then initially under XVI) were replaced by a “minimum benefit” provided directly by the Social Security Administration.⁴

In 1973, the resource limit for SSI was \$1,500 for an individual and \$2,250 for a couple; the only exclusions were a home of “reasonable value” (established by regulation as worth \$25,000), a car (unless needed for medical care or work) of “reasonable value” (established by regulation as worth \$1,200), life insurance with a face value of \$1,500, and personal effects/household goods not exceeding \$1,500 in value. (The law was changed in 1976 to exclude a home of any value.⁵)

Optional State Programs of Supplementation

Public Law 92-603 also allowed states the option of “supplementing” the SSI benefit,⁶ and Connecticut amended its statute⁷ accordingly to reference an “optional program of supplementation.” The concept of the “supplement” is that SSI would not “count” a state’s supplement as income reducing the SSI benefit, provided the supplement program complied with federal requirements.⁸ If the program did not comply with federal requirements, then the recipient could lose SSI, which would impose a greater welfare obligation (or at least, welfare problem) for the recipient’s state of residence. Social Security Act §§ 1616-1618⁹ provide certain basic minimum requirements, as set forth further in the Code of Federal Regulations.¹⁰ Moreover, in Section 212 of Public Law 93-66, Congress made a state’s eligibility for funding under the Medicaid (Title XIX) program contingent upon having in place a state supplement meeting a “mandatory minimum” level for those individuals who had been receiving benefits prior to the establishment of SSI as a federally administered program, or December, 1973.¹¹ Successive Public Laws required states to maintain supplementation at the

levels in effect on successive dates; the last of these required needs to be maintained at the pre-January, 1983 levels, subject to various changes in circumstances.¹²

Under Public Law 92-603 creating SSI, states could choose between administering the supplements themselves (as Connecticut has chosen) or to have the payments federally administered, with the Social Security Administration determining eligibility, making payments, and receiving an administrative fee from the State. (The law included a "hold harmless" for states that chose the latter option, limiting financial liability for the payments.) Connecticut, however, chose to self-administer. Its pre-existing "adult welfare" program statute was amended and restated to continue as the supplemental program to SSI.¹³

Not all states made Connecticut's choice to continue administering its own program. As of 2009, ten states (California, Delaware, District of Columbia, Hawaii, Massachusetts, Montana, Nevada, New Jersey, Rhode Island, Utah) use only a federally-administered supplement program whereby the Social Security Administration sends out a combined check in all cases, with no state involvement whatsoever.¹⁴ In many other states, Social Security provides payment to those living in facilities, but the State provides the payment to individuals in the community.

The benefit provided also varies by state. As of January 2009, 33 states automatically provide supplemental benefits to all individuals receiving SSI.¹⁵ However, five states—Arkansas, Kansas, Tennessee, Mississippi, and West Virginia—don't supplement at all,¹⁶ and four states only supplement those who were receiving benefits prior to the enactment of SSI, the "mandatory minimum" recipients.

In Connecticut, the benefit is administered through the Connecticut Department of Social Services. The AABD benefit is determined based on a needs analysis, using a complicated formula that takes into account actual rental and other expenses, as explained below. This "needs" approach is authorized under federal regulations¹⁷ that explicitly allow states to set up plans differentiating payment based on living arrangements, including different rates for those in congregate living situations.¹⁸ The "needs" approach is also a holdover from Connecticut's pre-SSI APT programs, which also used a living budget approach.

AABD—the Nuts and Bolts

Who Gets AABD?

Recipients of state supplement fall generally into two categories: (a) very low-income aged, blind, or disabled people living in the community, usually disabled people receiving SSI; and (b) those in "rated housing," namely aged, blind, or disabled residents of "licensed boarding facilities," typically residential care homes (formerly "homes for the aged") licensed as such by the Department of Public Health, or residents of certified "board and care" or group homes for the developmentally disabled.¹⁹

For those in the community (i.e., not residing in rated housing), the benefit takes the form of "cash assistance," accessed through a grey "Connect" Card that is also used for food stamps, QMB, and Medicaid.

For those in residential facilities, the benefit takes the form of a rental subsidy that is sometimes paid directly to the institution as a credit towards the state rate—in effect, the institution is the "representative payee" for the State Supp. that is payable to the resident—with the individual responsible for the difference. In other residential facilities, the State Supp. is paid directly to the resident or resident's representative, such as the conservator. In either case, the benefit is not a direct payment for the person's care, but a cash subsidy based on rental expenses.

For an elderly person living in a "residential care home" formerly known as a "home for the aged," the benefit may look and feel like Medicaid—payment goes to the facility directly; individual has an obligation

to pay part of income to the facility; apparently same asset rules; same benefit application (the form W-1-F). In fact, nine times out of ten the staff at a facility participating in the program will state that it “accepts Medicaid,” and even the Department of Public Health publication listing all licensed facilities in the state and specifying which accept Medicaid²⁰ and which do not lists residential care homes—facilities for which the federal Medicaid benefit is **not** available—as those that “accept Medicaid!” This is probably because a person eligible for State Supp. benefits is automatically, or “categorically,” eligible for Medicaid coverage of health care expenses.²¹ Therefore, a person in a residential care home with income of \$2,000 is automatically eligible for Medicaid. Notwithstanding, even if the person is eligible for and receiving Medicaid, Medicaid is not paying the institution’s bill—Medicaid won’t pay for care in a residential care home. Instead, the resident is simply receiving a rental subsidy from the State, tied to the home’s daily rates.

State Supp. Eligibility Rules

As with other benefits, AABD has functional and financial eligibility requirements. State Supp. is available to those who qualify as “aged” (65+), blind, or disabled (in other words, would meet SSI’s functional eligibility requirements), who have income, and who meet other requirements. Federal regulation permits states to impose a minimum residency requirement for State supplement benefits, although Connecticut’s statute no longer includes such a requirement.²²

(a) **Functional Eligibility.** The Department of Social Services can determine whether a person is “disabled” even if not receiving SSI or Social Security Disability, but if an application is pending with SSA, DSS may choose to wait, or to make its finding provisional only.²³ As for other limitations: residents of “public institutions” (e.g., prisons, State mental institutions) are ineligible for both SSI and State Supp., with some exceptions.²⁴

(b) **Receipt of Other Income.** At a technical level, to receive AABD an individual must either receive SSI or be eligible to receive it except for the fact that he or she has income in excess of the SSI standard. In practical terms, to be eligible for AABD, a person must either be receiving SSI, or receive (or be deemed to receive) some other source of income in excess of the SSI amount for which the person would qualify,²⁵ but which is below the standard of need. The benefit is “supplemental,” so it must be “supplemental” to other income. The income need not be SSI—a person with SSDI, or a veteran’s benefit, might be eligible for AABD.

(c) **Financial Eligibility.**

(1) **Income Limits.** State Supplement is **only** available to individuals whose gross income does not exceed 300 percent of SSI, currently (2012) \$2,094 per month. (Whether or not a benefit is awarded will depend upon a formula that takes into account living expenses, as described below.) Prior to the enactment of Public Act No. 09-73 (eff. July 1, 2009), the 300 percent SSI “income cap” was absolute, and no matter the circumstances, no benefit could be available to a person with income even as little as \$1 over the cap. Public Act 09-73 provides that excess income of individuals residing in residential care homes, if transferred to a “pooled trust account” described in 42 U.S.C. sec. 1396p(d)(4)(C), will not be counted for purposes of the cap. Note that income of a spouse who **lives with** the applicant will be deemed available to the individual.²⁶ Spouses living apart because one is in a licensed facility will not have income deemed to each other.²⁷ Certain types of income are excluded, such as Holocaust reparations, etc. A full list is included at UPM § 5015.10.F. Irregular gifts, not exceeding \$20/month are excluded.²⁸ In-kind income is also excluded, following rules used for SSI.²⁹ There is no deduction from income for the Medicare Part B premium, but that is because the AABD recipient will usually have such low income that he or she will be eligible for the QMB benefit which pays the Medicare Part B premium. (How this situation may be affected by the use of a pooled trust for a higher-income person residing in a boarding facility is not yet clear.)

(2) **Asset Limits.** The asset limit for State Supp. is \$1,600 in non-exempt assets.³⁰ So far, the similarity to Medicaid is clear. Excluded from consideration are the individual's home, car, funeral contract, and burial space. However, AABD asset rules contain certain major differences from the rules in the Medicaid program. First, the assets of a spouse who is not living with the applicant are not "deemed" or otherwise considered available to the applicant.³¹ That sounds positive, but the corollary is that there is no concept of a "CSPA" or spousal share that is protected—and, as noted below, these non-counted spousal assets may be liened. If the spouses live together, however, all assets are deemed available to each and may preclude eligibility.³² Second, assets in a self-settled "special needs trust" described in 42 U.S.C. § 1396p(d)(4)(A) are **not** exempt.³³ Third, while assets of a parent are generally "deemed" available to a minor child, there are exceptions where the child is residing in an institution or is blind.³⁴

(d) **Transfer Penalties.** AABD and Medicaid have both similarities and differences when it comes to transfer penalties, and the practitioner may need to keep in mind that what may work for a client's care in a residential care home will still come back to haunt the client if he or she must relocate to a nursing home later on. Among the differences: State Supp. has a 24-month look-back period.³⁵ Any non-exempt transfer during that period incurs penalty at the rate of \$500 = one month of ineligibility.³⁶ There is no cap on the penalty; however, the penalty starts to "run" in the month it is made, as the rules of DRA have not been applied to State Supp. transfer penalties.³⁷ Other important differences from Medicaid penalties:

- Transfers are **only** subject to penalty if made "for the purpose of qualifying," which is shown **only** if three factors apply:³⁸ (1) fair market value not received, (2) **no** convincing evidence that the transfer is for another purpose, and (3) transferor does not retain sufficient funds for foreseeable needs (i.e., sufficient to pay for 24 months in a nursing home³⁹); arguably, this imposes a greater burden on the State to show that a transfer should give rise to a penalty than under the Medicaid program.
- Transfers **between spouses** may be subject to penalty. An exception will be making a spouse a joint owner of property,⁴⁰ or division of property pursuant to a written agreement when the spouses begin to live separately (because one is in a licensed boarding facility).⁴¹
- A transfer **of the home** by an applicant residing in the community is not subject to a transfer penalty (following SSI rules that take the same approach).⁴²
- Other exemptions from penalty available under the Medicaid program are **not** available for AABD purposes. The primary exemptions are where there is undue hardship⁴³ or the transferor was incompetent at the time of transfer.⁴⁴
- Transfers of assets to a self-settled special needs trust (except transfers of income authorized by Public Act No. 09-73, discussed *supra*) are apparently subject to penalty;⁴⁵ arguably, as the assets are considered available, no transfer may have occurred.⁴⁶ At a minimum, spending down the trust should negate the penalty.

(e) **No Retroactive Benefits.** Eligibility for AABD begins the first day on which both are true: (a) the individual has applied and (b) all other eligibility requirements are met, including reduction of assets to the permitted limit.⁴⁷ Thus, unlike the Medicaid program, AABD does not provide any retroactive benefits. If a client resides in a residential care home and will be seeking eligibility for AABD, it is imperative to apply **and** to spend down immediately, rather than expecting to spend down by month's end with the possibility of three months' retroactive benefit. This tends to mean that "spending down" will involve paying the facility for the charges during the month of application.

(f) **Contribution by Legally Liable Relatives.** As with most programs, a “legally liable relative” (LLR) of an AABD applicant may be asked to contribute; federal regulations specifically authorize imposing a “legally liable relative” contribution requirement.⁴⁸ A spouse, even one not living with the recipient, is a “legally liable relative.” The contribution will be limited to 12 percent of the difference between the LLR’s prior year’s taxable income, and the Connecticut median income of the applicable family size.⁴⁹ In 2010, the median family income in Connecticut for a family of one was \$52,854.36; for a family of two, \$66,441.44.⁵⁰

(g) **Lien.** State Supp. is not limited by Medicaid law limiting liens; in fact, federal regulation specifically authorizes them.⁵¹ Anyone living in a home in the community will have a lien placed on the home as a condition of receiving State Supp.⁵² In addition, a lien may be placed on in-state real property owned by a legally liable relative (which might be a spouse) even if not living with the assistance unit.⁵³ Thus, if one spouse is in a residential care home on AABD, and the other is at home, the home might be liened—quite different from Medicaid rules that protect spouses against liens.

(h) **Estate Recovery.** State Supp. is also not limited by Medicaid restrictions on estate recovery. A current or former recipient of State Supp. who receives anything of value during lifetime is liable for repayment during lifetime, limited only by State law limitations on recovery from inheritances and personal injury settlements up to 50 percent of the amount received or recovered.⁵⁴ The State also has a claim against the estate of any decedent who received these benefits at any time during life.⁵⁵ The only limitation on the State’s claim is when the probate court rules that the estate is needed to provide for the support of the deceased beneficiary’s surviving spouse, parent, or dependent child under 21; no other spousal or other protections against estate recovery exist.⁵⁶

Computing Benefit Amount under State Supp.

(i) **Licensed Facility.** The AABD budget for a person residing in a licensed board facility is calculated by adding the monthly **State** rate of the particular facility⁵⁷ to a personal needs allowance of \$28.90⁵⁸ to reach the applicant’s “basic needs.” This is compared to the applicant’s income, **disregarding** \$209.70 (2012 figure).⁵⁹ The balance is deducted from the total needs and the facility receives a check for the difference. The applicant’s award letter will not say “Medicaid has been granted eff. (date); your obligation to pay applied income is \$2,002 in June, \$2,000 in July, \$2,000 in August (etc.)” Rather, the award letter may say “We will pay \$3,500 per month to the facility.” The facility and the individual must then agree about what is left over. The upshot, however, is that the applicant keeps \$28.90 + \$209.70 or \$238.60 and the rest goes to the facility. **Note:** there is no ability to deduct for supplemental insurance premiums. These must either be paid by the individual out of the \$214.60, or the insurance must be dropped. However, eligibility for State Supp. makes a person “categorically” eligible for Medicaid.⁶⁰

(j) **State Supp. in the Community.** For the person in the community, a/k/a not in “rated housing,” the “basic need” is actual rent up to a maximum of \$400 (if living alone) or \$200 (if sharing); DSS then computes “total need,” consisting of the basic needs amount, **plus** a personal needs allowance of \$164.10 (\$165.10 for a married individual),⁶¹ **plus** any “special needs.” (Personal needs allowance figures have remained constant for some time.) “Total need” is then compared to income (net of any disregard), and AABD makes up the difference. In 2012, the unearned income disregard for an individual in the community, living as a roomer in someone else’s home, or in a skilled nursing facility, was \$302; for someone sharing with a non-relative, the disregard was \$369.90 (increasing each year to reflect Social Security Administration adjustments, although the increase is at perpetual risk of elimination under repeated gubernatorial budget proposals).⁶² There are also “earned income” disregards. As with SSI, these will be the first \$65 of earned income plus 1/2 the remainder for a disabled person; the first \$85 plus 1/2 the remainder for a blind person (who was blind prior to age 65).⁶³

Work-related expenses are also added to the disregard, usually when the individual is on a Social Security Administration-approved plan to return to employment.

(k) Examples of How to Compute the Benefit

Example #1: Single individual in the community with SSI of \$698, rent of \$600.

"Basic need" is $\$400 + \164.10 (no special needs) or $\$564.10$.

"Income" is $\$698 - \$302 = \$396$.

$\$564.10 - \$396 = \$168.10$.

Individual gets \$698 from SSI (which doesn't reduce to reflect the supplement) plus \$168.10 from the state of Connecticut. (Individual probably also gets food stamps, which for many is \$200/month since 2009.)

Example #2: Single individual living at Seacrest (state rate: \$84.44/day,⁶⁴ \$2,533/mo).

"Basic need" is $\$2,533 + \$28.90 = \$2,561.90$.

"Income" is $\$698 - \$209.70 = \$488.30$.

$\$2,561.90 - \$488.30 = \$2,073.60$.

State pays facility \$2,073.60. Resident pays $\$2,533 - \$2,073.60 = \$459.40$, keeps \$238.60 (which coincidentally = $\$209.70 + \28.90).

(l) Additional Benefits. Recipients of AABD, both in the community and in licensed boarding facilities, are entitled to assistance with moving expenses in certain circumstances,⁶⁵ special clothing assistance,⁶⁶ help with purchase or repair of essential household items,⁶⁷ telephone installation,⁶⁸ therapeutic diets prescribed by a physician,⁶⁹ and meals on wheels for those in the community.⁷⁰ A person eligible for AABD residing in a nursing home, where SSI reduces to \$30/month, will also get an extra \$30 to make up the \$60 personal needs allowance permitted under Medicaid for individuals residing in skilled nursing facilities.

Notes

1. Kollman, Geoffrey, "Social Security: Summary of Major Changes in the Cash Benefits Program," Congressional Research Service Legislative Histories 2, No. RL30565, available on the Social Security Administration Web site (March 14, 2010), www.socialsecurity.gov/history/reports/crsleghist2.html.
2. Source: interview with Anne Popolizio, former DSS employee.
3. Social Security Bulletin 2000, *Annual Statistics Supplement*, available on the Social Security Administration Web site (March 14, 2010), www.socialsecurity.gov/history/pdf/ssi.pdf.
4. Kollman, *supra*.
5. Social Security Bulletin 2000, *supra*.
6. Social Security Act, Title XVI, § 1616; 42 U.S.C. 1382e.
7. 1972 Public Act No. 61; 1972 June Special Session Public Acts No. 1, Section 13, enacting Conn. Gen. Stat. § 17-109, which has since been replaced by Conn. Gen. Stat. § 17b-600.
8. 42 U.S.C. § 1382e(a).
9. 42 U.S.C. §§ 1382e-1382g.
10. 20 C.F.R. § 416.2001.
11. P.L. 93-66, 87 Stat. 152; see 20 CFR sections 416.2001(c); see also "State Assistance Programs for SSI Recipients, January 2009," available on the Web site of the Social Security Administration (March 14, 2010) at http://www.ssa.gov/policy/docs/progdesc/ssi_st_asst/2009/ssi_st_asst09.pdf.
12. 20 C.F.R. §§ 416.2096; apparently this was brought up to 1988 levels in Connecticut—see, e.g., Transmittal UP-88-49 (UPM § 4525.65, "Conversion Need Items").
13. Conn. Gen. Stat. §§ 17b-600 et. seq.
14. "Understanding Supplemental Security Income SSI Benefits, 2010 Edition," available at <http://www.socialsecurity.gov/ssi/text-benefits-ussi.htm> (April 6, 2010).
15. "State Assistance Programs for SSI Recipients, January 2009 (released October 2009)," available on the Web site of the Social Security Administration (March 14, 2010) at http://www.ssa.gov/policy/docs/progdesc/ssi_st_asst/2009/.

16. "Understanding Supplemental Security Income SSI Benefits, 2010 Edition," *supra* n.14.
17. 20 C.F.R. § 416.2001(a)(4).
18. 20 C.F.R. § 416.2030
19. UPM § 4520.10.A.1.a, A.2.
20. *Nursing Home Facilities Licensed by the State of Connecticut (Chronic and Convalescent Nursing Homes, Rest Homes with Nursing Supervision, Residential Care Homes)*, published by State of Connecticut Department of Public Health; as of 4/7/2010, no longer available for purchase as a printed copy but available online at: http://www.ct.gov/dph/lib/dph/facility_licensing_and_investigations/pdf/nursing_home_book.pdf.
21. UPM § 2540.72.
22. 20 C.F.R. § 416.2035(a).
23. UPM § P-2530.05.
24. 20 C.F.R. § 416.2040; "public institution" defined at 20 C.F.R. § 416.201. UPM 3015.05 also sets forth certain situations in which residents of mental institutions remain eligible for AABD, typically those under 21 or over 65.
25. Department of Social Services Uniform Policy Manual (UPM) § 3030.05.B.1.
26. UPM § 5020.70.
27. *Id.*
28. UPM § 5015.10.F.4.
29. UPM § 5015.10.F.5, referencing UPM § 5050.
30. UPM § 4005.10.
31. UPM § 4025.55.
32. UPM § 4025.55.
33. *Parkhurst v. Department of Social Services*, 82 Conn. App. 877 (2004).
34. UPM § 4025.55.
35. Conn. Gen. Stat. § 17b-600; UPM § 3025.05.
36. UPM § 3025.35.B.3.b.
37. UPM § 3025.
38. UPM § 3025.10.
39. UPM § 3025.15.E.
40. UPM § 3025.15.
41. UPM § 3025.25.D.3.b; UPM P-3025.18.
42. Conn. Gen. Stat. § 17b-600; UPM § 3025.15.G.2.
43. UPM §§ 3025.05.B.1, 3025.25.
44. UPM § 3025.05.B.2.
45. *Parkhurst*, *supra* n.31.
46. *Id.*
47. UPM § 1560.05.
48. 20 C.F.R. § 416.2035.
49. UPM § 7520.05.C.
50. UPM § P-7520.10, UP-09-10.
51. 20 C.F.R. § 416.2035.
52. UPM § 7510.10.
53. *Id.*
54. Conn. Gen. Stat. § 17b-93, 17b-95.
55. UPM § 7520.05.
56. UPM § 7520.05.D.3.
57. UPM § 4520.10.C.
58. UPM § 4520.10; *note*: all figures are those in effect April, 2010. Note that for a resident of a skilled nursing facility, the PNA is \$50.00 for purposes of AABD eligibility. UPM § 4520.20.
59. UPM § 5030.15; P-5030.15 (Transmittal UP 08-25).
60. UPM § 2540.72.
61. UPM § 4520.15.
62. UPM § P-5030.15.
63. UPM § 5030.10.
64. State rate obtained from Department of Social Services; chart showing state daily rates for residential care homes under AABD may be found (April 7, 2010) at: <http://www.sharinglaw.net/elder/RCHrates.xls>.
65. UPM § 4525.15.
66. UPM § 4525.20.
67. UPM § 4525.25.
68. UPM § 4525.55.
69. UPM § 4525.60.
70. UPM § 4525.10.