STATE OF NORTH CAROLINA

COUNTY OF WAKE

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
14 INS 08876

Angela B O'Connell Petitioner, v. NC Teachers' and State Employees' Comprehensive Major Medical Plan A/K/A The State Health Plan Respondent.	**FINAL DECISION**

THIS MATTER comes forward on Petitioner's filing of a contested case petition with the Office of Administrative Hearings appealing Respondent's coordination of Petitioner's State Health Plan benefits and claims pursuant to N.C.G.S. § 135-48.38. On April 8, 2015, Respondent filed a Motion to Dismiss, and in the alternative, a Motion for Summary Judgment. On or about April 20, 2015, Petitioner filed a Motion for Partial Summary Judgment. On May 1, 2015, Respondent filed a Response to Petitioner's Motion for Partial Summary Judgment. On August 24, 2015, the Undersigned issued an Order denying Respondent's Motion to Dismiss and Motion for Summary Judgment as well as denying Petitioner's Motion for Partial Summary Judgment. On October 30, 2015, the Undersigned conducted an administrative hearing in this case. At the end of the hearing, the Undersigned requested each party to submit closing arguments within two (2) weeks from receipt of the hearing transcript. On December 15, 2015, the parties submitted closing arguments. In April 2016, Respondent submitted its proposed final decision and on May 3, 2016 Petitioner submitted exceptions to Respondent's proposal.

APPEARANCES

For the Petitioner:
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Attorney for Petitioner
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For the Respondent:
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ISSUE

Did the Respondent act arbitrarily and capriciously when, upon learning of Petitioner's Medicare eligibility status due to disability, it coordinated benefits and re-processed Petitioner's claims with Medicare as primary and the State Health Plan as secondary pursuant to N.C.G.S. § 135-48.38?

RELEVANT STATUTES AND POLICIES

N.C. Gen. Stat. Chap. 135; N.C. Gen. Stat. Chap. 150B, Article 3; and, the State Health Plan PPO Benefits Booklets; Medicare Secondary Payer Manual.

EXHIBITS ADMITTED INTO EVIDENCE

For the Petitioners: Exhibits 1-28
For the Respondent: Exhibits 1-24

WITNESSES

For the Petitioners:
Angela O'Connell, Petitioner
Albert O'Connell
Mary Leigh Inscoe

For the Respondent:
Caroline Smart, Chief Operating Officer, North Carolina State Health Plan

BASED UPON careful consideration of the sworn testimony of the witnesses presented at the hearing, the documents, exhibits received and admitted into evidence, and the entire record in this proceeding, the undersigned Administrative Law Judge makes the following Findings of Fact by a preponderance of the evidence. In making these Findings of Fact, the Undersigned has weighed all the evidence and has assessed the credibility of the witnesses, taking into account the appropriate factors for judging credibility, including, but not limited to the demeanor of the witnesses, any interest, bias, or prejudice the witness may have, the opportunity of the witness to see, hear, know or remember the facts or occurrences about which the witness testified, whether the testimony of the witness is reasonable and whether the testimony is consistent with all other believable evidence in this case.

FINDINGS OF FACT

1. Respondent State Health Plan is an agency of the State of North Carolina, and offers optional healthcare plans and health care benefits to eligible active and retired employees, and their enrolled dependents in accordance with the applicable North Carolina General Statutes, the Benefit Booklets for Respondent's preferred provider organization plan (hereinafter "PPO") and Respondent's health care policies.

2. The State Health Plan became a division of the Office of State Treasurer effective January 2012. The State Treasurer is a fiduciary of the State Health Plan, State Health Plan

members, and trust funds established by statute to pay State Health Plan member's benefits and claims.

3. Blue Cross Blue Shield of North Carolina ("BCBSNC") is the third party administrator and claims processor for the State Health Plan and, as such, administers and processes State Health Plan member claims, billing, and coordination of benefits.

4. State Health Plan member healthcare benefits under the State Health Plan, and how member claims are processed and paid are provided for in North Caroline General Statutes and in the specific health plan a member is enrolled in under the State Health Plan.

5. Caroline Smart, Chief Operating Officer at the State Health Plan testified at hearing that Respondent correctly followed and applied N.C.G.S. § 135-48.38 to Petitioner's healthcare claims. Pursuant to N.C.G.S. § 135-48.38, the State Health Plan becomes secondary coverage and Medicare primary coverage for certain Medicare eligible Plan members. N.C.G.S. § 135-48.38 also describes the benefits and payment of claims for State Health Plan members eligible for Medicare. (Respondent's Ex. 1)

6. In September 2011, the Office of the State Auditor conducted a performance audit regarding the State Health Plan which found:

> The Plan is also at risk for overpaying medical claims because the Plan has not taken action to prevent coordination of benefits errors. Those errors occur when BCBSNC pays a Plan member's medical claim when Medicare or another insurance provider should have paid all or part of a claim first. Plan management is aware the risk for coordination of benefits errors because BCBSNC auditors recovered about $8.4 million in errors on the Plan's behalf between January, 2007 and September 2010. However, during the audit period the Plan did not take steps to confirm whether all coordination of benefits errors were recovered or analyze the errors to determine why they occurred. Furthermore, although the Plan requested corrective action plans for errors identified by its auditor during the audit period, the Plan did not require its claims processor, BCBSNC, to conduct a detailed analysis of all errors or to develop or implement policies and procedures to prevent future coordination of benefit errors. While the Plan has recently worked with BCBSNC to develop reports to track the recovery rate of coordination of benefits errors, more work is required on root cause analysis and process improvement to prevent future coordination of benefit errors. (Petitioner Exhibit 1).

7. Petitioner left employment with Franklin County Schools in 2011. When Petitioner's active employment with Franklin County School ended, Petitioner was required to reenroll in the State Health Plan in order to receive benefits under the State Health Plan. Petitioner is currently a member in the State Health Plan in the retiree group. Petitioner has maintained her retiree State Health Plan coverage since October 2011 and has continuously paid her premiums for coverage.

8. On August 9, 2011, the North Carolina Retirement Systems Division in the Office of State Treasurer received a form titled "Selecting Health Coverage Through the State Health Plan" ("HM form"), for Angela O'Connell signed and dated by her. (Respondent's Ex. 5)

9. Section H of the HM form included a section regarding Medicare eligibility which stated that "Medicare Parts A and B are required to continue the same level of coverage when you or dependents become Medicare eligible." (Respondent's Exhibit 5) Petitioner, with the assistance of her husband, and her husband read this section of the HM form before Petitioner signed the form and submitted the form to the North Carolina Retirement Systems Division in August 2011.

10. Petitioner was awarded Social Security Disability ("SSD") by the Social Security Administration in January 2011. (Petitioner's Ex. 7)

11. Petitioner became eligible for Medicare Parts A and Part B in 2012. The Social Security Administration notified Petitioner of her Medicare Parts A and B eligibility by letter dated October 2012. (Petitioner's Ex. 7, 19)

12. Petitioner applied for and received short-term and long-term disability through the Disability Income Plan of North Carolina. The State's disability process for short and long term disability is a separate process than the federal process for SSD. Not all employees who receive State disability receive SSD or become eligible for Medicare. Petitioner's application and receipt of State short-term and long-term disability through the Disability Income Plan of North Carolina did not affect her coverage under Medicare or the State Health Plan. Petitioner took steps to review written information provided by the State Health Plan to understand her benefits while transitioning to disability retirement, including reviewing The State Health Plan for Teachers and State Employees 2011/2012 Benefit Year Annual Enrollment Information Booklet.

13. After her eligibility and award of Medicare Parts A and B, Petitioner elected to opt out of Medicare Part B coverage in November 2012. In order to decline Medicare Part B, Petitioner returned documentation to the Social Security Administration indicating that she declined Medicare Part B.

14. In 2014, the Plan conducted an audit and discovered members, including Petitioner, who were no longer actively employed and were Medicare eligible due to disability, but had failed to notify the State Health Plan of their Medicare eligibility status.

15. After the audit findings, the State Health Plan retroactively applied N.C.G.S. § 135-48.38 to the applicable members, including Petitioner, and reprocessed their claims.

16. Medicare Secondary Payer Rules limit the ability of health plans to retroactively reprocess member healthcare claims as secondary coverage. Pursuant to Medicare Secondary Payer Rules, the State Health Plan limited the reprocessing of members' healthcare claims to one year retroactive.

17. On or about September 11, 2014, Petitioner received a letter from the State Health Plan which stated their records indicated "that you have recently or will soon become Medicare Primary," and that as "your enrollment was received less than sixty (60) days prior to the benefit effective date, you have been automatically enrolled in the Traditional 70/30 PPO Plan until the end of the benefit year, which ends De. 31, 2014." (Petitioner Exhibit 21)

18. By letter dated September 17, 2014, the State Health Plan notified Petitioner that the Plan would retroactively reprocess her healthcare claims with Medicare as primary coverage and the Plan as secondary coverage, with an effective date of September 1, 2013. Further, the State Health Plan notified Petitioner that the reprocessing of claims may result in her providers having to file claims with Medicare as primary, and that if she was not enrolled in Medicare Part B as of September 1, 2013, the re-processing of her claims may result in her owing additional reimbursement to her providers for services received during this time. (Respondent's Ex. 4)

19. The September 17, 2014 letter also notified Petitioner that: "You must enroll in Medicare Part B in order to receive full benefit coverage when Medicare is primary….you are responsible for the amount that would have been paid by Medicare Part B if you do not enroll in Medicare Part B." (Respondent's Ex. 4)

20. The State Health Plan applied N.C.G.S. § 135-48.38 and the Medicare Secondary Payer Rules to Petitioner and reprocessed her healthcare claims retroactively to September 1, 2013, with Medicare as primary coverage and the State Health Plan as secondary coverage. Petitioner became responsible for the amounts of her claims that would have been paid by Medicare Part B, due to her decision to decline Medicare Part B when she became eligible in 2012.

21. On November 14, 2014, Petitioner filed a contested case petition with the Office of Administrative Hearings alleging that Respondent did not provide Petitioner with timely notice of its intent to only provide secondary coverage once Petitioner became Medicare eligible and appealing Respondent's coordination of Petitioner's State Health Plan benefits and claims pursuant to N.C.G.S. § 135-48.38.

22. Petitioner raised an estoppel argument as part of her contested case before this administrative tribunal. Petitioner alleged that the State Health Plan should be equitably estopped from applying N.C.G.S. § 135-48.38 to her in this case. Petitioner contends that she made the decision to decline Part B in reliance upon the representations made by Franklin County Schools' employee, Mary Leigh Inscoe, as well as materials provided by Respondent.

23. The State Health Plan Benefits Booklets describe the terms of healthcare coverage applicable to State Health Plan members during each plan year, and are made available every year to Plan members such as Petitioner. (Respondent's Ex. 11-17) At the time she left employment with Franklin County Schools in 2011, Petitioner was enrolled in the 80/20 PPO Plan. Petitioner remained enrolled in the 80/20 PPO Plan until September 2014.

Pages 46-47 of the 2011 State Health Plan Standard 80/20 PPO Plan Benefits Booklet, under "State Health Plan Benefit Coordination with Medicare," provides that:

> "if you are retired and eligible for Medicare, the *State Health Plan* becomes secondary coverage. Medicare is also primary and the *State Health Plan* secondary for the following **Medicare-eligible** individuals:
> - [r]etirees
> - [d]isability retirees,
> - [i]ndividuals who have Medicare because of disability and who are not actively working…." (emphasis in original)
>
> The above language is also featured in the 2009, 2010, 2012, 2013, and 2014 80/20 Plan Benefits Booklets. (Respondent's Ex. 11-17)

24. Page 47 of the 2011 State Health Plan Standard 80/20 PPO Plan Benefits Booklet, under "Important Information About Medicare Part B," provides that:

> "If you are covered under the *State Health Plan* as a *member* or a *dependent* of a *member*, and you are eligible under Medicare Part B, **your benefits under the State Health Plan will be paid as if you are enrolled for coverage under Medicare Part B, regardless of whether you have actually enrolled for such coverage**. In other words, even if you have not enrolled in Medicare Part B coverage, your health benefit plan will reduce your claim by the benefit that would have been available to you under Medicare Part B, and then pay the remaining claim amount under the terms of your health benefit plan. **As a result, you are responsible for the amount that would have been paid by Medicare Part B if you do not enroll in Medicare Part B**." (emphasis in original)
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> The above language is also featured in the 2009, 2010, 2012 2013, and 2014 80/20 Plan Benefits Booklets. (Respondent's Ex. 11-17)

25. The "Members Rights and Responsibilities" section in the 2011 80/20 Benefits Booklets provides that "[a]s a State Health Plan Member, you have the responsibility to: Notify your employer and the State Health Plan if you have any other group coverage". The same language is featured in the 2009, 2010, 2012, 2013, and 2014 80/20 Plan Benefits Booklets. (Respondent's Ex. 11-17)

26. Materials made available by the North Carolina Retirement Systems Division provided notice to State Health Plan members, such as Petitioner, of the need to elect Medicare Part B to maintain their same level of coverage. Page 21 of the January 2011 Retirement Systems Division's Retirement Handbook titled "Your Retirement Benefits Teachers and State Employees Retirement System," provides that: "As a retiree, when you or covered dependents become eligible for Medicare, both Parts A (Hospital) and B (Medical) must be elected to maintain the same level of coverage provided before retirement." (Respondent's Ex. 9)

27. Prior to her leaving active employment in 2011, Petitioner and her husband met with Franklin County Schools Human Resources Benefits Specialist, Mary Leigh Inscoe. During these meetings, Petitioner and her husband did not ask about the effects of Medicare eligibility on State Health Plan benefits, nor did Mary Leigh Inscoe ever inform Petitioner or her husband that Petitioner did not need to enroll in Medicare Part B.

28. At hearing, Ms. Inscoe testified that if Petitioner or Petitioner's husband had inquired about the impact of Medicare eligibility on her State Health Plan coverage, she would have told them that Medicare would be Petitioner's primary coverage, and the State Health Plan would become her secondary coverage once she became eligible for Medicare Parts A and B.

29. Petitioner's husband, Al O'Connell, has power of attorney to make decisions and take action on Petitioner's behalf such as enrolling her in, reviewing, managing, and assisting in her healthcare and disability benefits, and reviewing and managing her correspondence and dealings with the State Health Plan.

30. When Petitioner received notice that she was eligible for Medicare Parts A and B in October 2012, Petitioner received a packet of information from the Center for Medicaid and Medicare Services ("CMS") that advised her that there could be a penalty for failing to enroll in Medicare Part B when first eligible, that Petitioner should contact her healthcare plan to find out how her healthcare plan worked with Medicare, and that Petitioner may be required to enroll in Medicare Part B.

31. Petitioner and her husband did not notify the State Health Plan or the State Retirement Systems Division when Petitioner became eligible for Medicare.

32. Petitioner and her husband were provided information regarding the need to elect both Medicare Parts A and B before she became eligible for Medicare in 2012, through information provided on the North Carolina Retirement Systems Division HM form that Petitioner filled out and signed in order to enroll in the State Health Plan, after she left active employment. (Respondent's Ex. 5)

33. Petitioner and her husband did not contact the State Health Plan or the North Carolina Retirement Systems Division prior to declining Medicare Part B to find out what effect declining Medicare Part B would have on Petitioner's coverage under the State Health Plan.

34. Petitioner and her husband did not review any State Health Plan Benefits Booklets for information regarding the effect of Petitioner's Medicare eligibility on her benefits under the State Health Plan when she became eligible for Medicare Part A and B or before she declined Medicare Part B. Petitioner's husband first reviewed the State Health Plan Benefits Booklets for information regarding the effect of Petitioner's Medicare eligibility on her benefits under the State Health Plan two years after Petitioner became eligible for Medicare.

35. Petitioner and her husband did not review any materials made available by the North Carolina Retirement Systems Division before Petitioner declined Medicare Part B. Petitioner and her husband did not notify the State Health Plan of her Medicare eligibility and receipt.

BASED UPON the foregoing findings of fact and upon the preponderance or greater weight of the evidence in the whole record, the Undersigned makes the following Conclusions of Law.

CONCLUSIONS OF LAW

1. The Office of Administrative Hearings has jurisdiction over the parties and subject matter of this action. Petitioner timely filed the petition for contested case hearing. The parties received proper notice of the hearing in this matter.

2. To the extent that certain portions of the foregoing Findings of Fact constitute mixed issues of law and fact, such Findings of Fact shall be deemed incorporated herein by reference as Conclusions of Law.

3. A court need not make findings as to every fact that arises from the evidence and need only find those facts which are material to the settlement of the dispute. Flanders v. Gabriel, 110 N.C. App. 438, 440, 429 S.E.2d 611, 612, aff'd, 335 N.C. 234, 436 S.E.2d 588 (1993).

4. Petitioner has the burden of proof, by a preponderance of the evidence, regarding the issues presented in this contested case. N.C. Gen. Stat. § 150B-34.

5. With N.C. Gen. Stat. Chapter 135, the General Assembly created an optional State Health Plan for the benefit of its State employees, retired employees and their eligible dependents. Pursuant to N.C. Gen. Stat. Chapter 135, Respondent is to provide comprehensive medical coverage under a group plan and benefits are to be provided under contracts between the Plan and the claims processor.

6. N.C.G.S. § 135-48.30 requires the State Treasurer to administer the Plan in accordance with the provisions of Chapter 135. Pursuant to N.C.G.S. § 147-68, the Treasurer may not pay moneys out of the treasury for payment of claims, absent a specific legislative directive.

7. N.C.G.S. § 135-48.5 creates trust funds for the payment of hospital and medical benefits under the Plan. State Health Plan members' benefits and claims are paid out of a health benefit trust funds established pursuant to N.C.G.S. § 135-48.5.

8. N.C.G.S. § 135-48.38 governs how benefits and claims are to be paid for Medicare eligible persons enrolled in the State Health Plan. Pursuant to N.C.G.S. § 135-48.38, the State Health Plan serves as secondary coverage, while Medicare provides primary coverage for certain Medicare eligible State Health Plan members, and describes the benefits and

payment of claims for State Health Plan members eligible for Medicare. N.C.G.S. § 13548.38 (a), (b), and (c) provide:

> (a): "Benefits payable for covered expenses under this Plan will be reduced by any benefits payable for the same covered expenses under Medicare, so that Medicare will be the primary carrier except where compliance with federal law specifies otherwise."
>
> (b): "For those [Plan] participants eligible for Medicare, the Plan will be administered on a "carve-out" basis. The provisions of the Plan are applied to the charges not paid by Medicare (Parts A & B). In other words, those charges not paid by Medicare would be subject to the deductible and coinsurance of the Plan just as if the charges not paid by Medicare were the total bill."
>
> (c): "For those individuals eligible for Part A (at no cost to them), benefits under this program will be reduced by the amounts to which the covered individuals would be entitled to under Parts A and B of Medicare, even if they chose not to enroll in Part B."

9. Sole authority rests with the General Assembly to authorize how coverage under the State Health Plan may be provided, and how funds may be expended to pay for healthcare coverage and claims under the State Health Plan. "Only the General Assembly may amend or rewrite a statute. N.C. Const. Art. II, § 1." Ramsey v North Carolina Veterans Comm., 261 N.C. 645, 648, 135 S.E.2d 659, 661 (1964).

10. N.C.G.S. § 135-48.38 applied to Petitioner when she became eligible for Medicare Parts A and B in October 2012.

11. The principles of estoppel cannot be used to award a remedy which extend the coverage authorized by Chapter 135 and specifically, N.C.G.S. § 135-48.38. *See* Wallace v. Bd. of Trs., Local Gov't Emples. Ret. Sys., 145 N.C. App. 264, 277, 550 S.E.2d 552, 560-61 (2001) ("[A]n estoppel argument does not apply" if "it would override what is clearly written in statute.")

12. Even if estoppel could be applied to this case, Petitioner failed to meet her burden of proving each required element of equitable estoppel. Petitioner failed to demonstrate that she lacked the knowledge, or lacked the means to understand the measure of benefits actually available through the State Health Plan, in conjunction with her award of Medicare, nor did Petitioner provide any evidence of a false representation, misrepresentation, or a concealment of material fact by Respondent or any agent of Respondent.

13. Petitioner was properly provided notice of the effect of Medicare Parts A and B eligibility on her State Health Plan coverage, and the effect that declining Medicare Part B would have on her coverage under the State Health Plan, through the State Health Plan Benefits

Booklets applicable to Petitioner. The State Health Plan Benefits Booklets informed Petitioner of her obligation to notify the Plan of her Medicare eligibility, the effects of Medicare eligibility, and the impact that declining Medicare Part B would have on Plan coverage.

14. Petitioner was further properly provided notice of the effect of Medicare Parts A and B eligibility on her State Health Plan coverage and the effect that declining Medicare Part B would have on her coverage under the State Health Plan through materials made available through the North Carolina Retirement Systems Division, including but not limited to the North Carolina Retirement Systems Division HM form that she signed on August 6, 2011.

15. Petitioner's application and receipt of State short-term or long-term disability benefits through the Disability Income Plan of North Carolina did not impact her eligibility or coverage under Medicare or the State Health Plan pursuant to N.C.G.S. § 135-48.38, nor did it communicate notice to Respondent of her future eligibility and award of Medicare.

16. Petitioner's right to coverage under the State Health Plan is authorized by Chapter 135, and she does not have a contractual right to primary coverage under the State Health Plan in violation of N.C.G.S. § 135-48.38. N.C.G.S. § 135-48.38 does not preclude the State Health Plan from retroactively processing Petitioner's claims

17. A preponderance of the evidence shows that the State Health Plan properly applied N.C.G.S. § 135-48.38 to Petitioner. Petitioner did not meet her burden of proving that Respondent acted arbitrarily and capriciously when, upon learning of Petitioner's Medicare eligibility status, it coordinated benefits and re-processed Petitioner's claims with Medicare as primary and the State Health Plan as secondary pursuant to N.C.G.S. § 135-48.38.

BASED UPON the foregoing Findings of Fact and Conclusions of Law the Undersigned makes the following Final Decision.

FINAL DECISION

The Undersigned finds and holds that there is sufficient evidence in the record to properly and lawfully support the Conclusions of Law cited above. The Undersigned enters the following Final Decision based upon the preponderance of the evidence, having given due regard to the demonstrated knowledge and expertise of the Agency with respect to facts and inferences within the specialized knowledge of the Agency.

Based upon the foregoing Findings of Fact and Conclusions of Law, the Undersigned holds that Petitioner failed to carry her burden of proof by a greater weight of the evidence regarding the issues presented in this contested case. The finder of fact cannot properly act upon the weight of evidence, in favor of the one having the *onus*, unless it overbears, in some degree, the weight upon the other side. The weight of Petitioner's evidence does not overbear the weight of evidence of Respondent to the ultimate issues, and as such Respondent's decisions to coordinate benefits and re-process Petitioner's claims with Medicare as primary and the State Health Plan as secondary pursuant to N.C.G.S. § 135-48.38 is Affirmed.

NOTICE

THIS IS A FINAL DECISION issued under the authority of N.C. Gen. Stat. § 150B-34.

Under the provisions of North Carolina General Statutes Chapter 150B, Article 4, any party wishing to appeal the Final Decision of the Administrative Law Judge may commence such appeal by filing a Petition for Judicial Review in the Superior Court of the county where the person aggrieved by the administrative decision resides, or in the case of a person residing outside the State, the county where the contested case which resulted in the Final Decision was filed. The appealing party must file the petition within 30 days after being served with a copy of the Administrative Law Judge's Final Decision. N.C. Gen. Stat. §150B-46 describes the contents of the Petition and requires service of the Petition on all parties. This Final Decision was served on the parties as indicated on the Certificate of Service attached to this Final Decision.

Under N.C. Gen. Stat. §150B-47, the Office of Administrative Hearings is required to file the official record in the contested case with the Clerk of Superior Court within 30 days of receipt of the Petition for Judicial Review. Consequently, a copy of the Petition for Judicial Review must be sent to the Office of Administrative Hearings at the time the appeal is initiated in order to ensure the timely filing of the record.

IT IS SO ORDERED.

This the 23rd day of June, 2016.

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Augustus B Elkins II
Administrative Law Judge