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STATE OF NORTH CAROLINA

COUNTY OF MECKLENBURG

IN THE OFFICE OF
ADMINISTRATIVE HEARINGS
22 INS 01542

Richard D Kingsberry Petitioner, v. North Carolina State Health Plan Respondent.	**FINAL DECISION**

THIS MATTER PRESENTS following *hearing on the merits* in Albemarle on 04 November 2022 before Jonathan S. Dills, Administrative Law Judge ("ALJ") with the Office of Administrative Hearings (OAH"); with authority of the state Constitution (Art 3, Sec 11, *accord*, Art IV, Sec 3), GS § 7A-750, GS § 150B (the "APA"), and NCAC, title 26; for *Final Decision*.

The ALJ is to determine the facts of a case, reach conclusions of law, and then "decide the case" within the bounds of law and therefore justice. GS § 150B-34(a).

APPEARANCES

For Petitioner: Richard D. Kingsberry, *pro se*
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For Respondent: Tamara M. Van Pala Skrobacki
Special Deputy Attorney General
North Carolina Department of Justice
Post Office Box 629
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WITNESSES

For Petitioner: Petitioner
Gloria D. Kingsberry ("spouse")

For Respondent: Jane Schairer, Customer Experience Specialist for the NC State Health Plan

EXHIBITS ADMITTED

Respondent submitted the following Exhibits into evidence:

Ex 1 Denied Exception Request Form of Spouse (Redacted)
Ex 2 Exception Request, Denial Email with Initial Denial Letter
Ex 3 Exception Request, Appeal Denial Letter to Petitioner
Ex 4 2022 Rate Sheet for Medicare Primary Plans
Ex 5 ID Card to Spouse (Redacted)
Ex 6 Humana Letter to Spouse Enrolled in Other Plan (Redacted)
Ex 7 Humana Letter to Spouse Enrollment Cancellation (Redacted)

ISSUE

Whether Respondent substantially prejudiced Petitioner's rights and acted erroneously or otherwise violated GS § 150B-23(a), by denying his request for retroactive change to his spousal health coverage and refund of premiums deducted.

RULING

BASED UPON careful consideration of the entire record; having weighed all the evidence and assessing the credibility of each witness by considering appropriate factors for judging credibility including, demeanor, interests, biases, and prejudices; the opportunity to see, hear, know, and remember; reasonableness; and consistency with all other believable evidence; the undersigned makes the following:

FINDINGS

1. Both parties are properly before this Tribunal; Petitioner received notice of agency action and timely appealed; the parties received appropriate notice of hearing; and no party has otherwise objected.

2. Credible evidence indicates Petitioner is a retired state employee and his dependent spouse was properly enrolled in a group Medicare plan with 90/10 coverage within the State Health Plan ("Plan") at very low cost ($4/mos).

3. Respondent alleges (but fails to prove) receiving accurate indication that the spouse enrolled in another individual Medicare plan that duplicated primary coverage. Upon proper notice of such duplication (here contested), the agency is required to move the spouse into a 70/30 plan at significantly increased cost (here $425/mos).

4. Apparently, Medicare tracks and flags duplicative, primary coverages. With credible indication, Medicare notifies the prior carrier via a *data file*.

5. Here allegedly, Humana received such notification re duplication with Aetna; Humana canceled coverage and notified the Plan which placed the other coverage; and Humana (only) sent notice of cancellation to the spouse (only). Exs. 6 & 7.

6. Respondent credibly evinces Medicare regulations are in play and its conduct in all this is proper and lawful. Plan information is *available* on this and a host of other such matters yet the Tribunal notes that even the best and brightest can suffer confusion.

7. Rationale for these machinations lies within multiple levels of competing interests in government, the market, and insureds. We want members to have proper coverage, decision authority, competitive choices, curtailed/offset abuse, and low costs. However, Petitioner is left wondering why the contingency plan is to charge much more for less.

8. No witness for Aetna, Medicare, or Humana, testified.

9. Respondent's witness acknowledged duties owed Petitioner, balanced by duties owed in the aggregate to all members. Fiduciary obligations were at least mentioned or alluded. Regardless, the Tribunal recognizes this difficult balance.

10. The witness further acknowledged Petitioner was entitled to notice, but that Humana's notices combined with their posted website information were reasonably sufficient.

11. The subject notices were directed only to the spouse, did not originate from the agency, and were introduced with little to no competent evidence of even being mailed.

12. The Tribunal notes that issues of notice and postings are not practically implicated without competent evidence that there was duplication of coverages.

13. Respondent describes Humana as a third-party administrator. Little detail was offered re its interplay with the Plan. Exhibits 6 & 7 reference the Plan in letterhead and insinuate in footers that Humana is a Plan affiliate *via* "Medicare contract."

14. The Plan attempts to educate members in advance re predatory insurance practices.

15. Petitioner credibly claims he never enrolled his wife with Aetna, did not receive notice of the coverage change, and never would have intended the significant increase in premium. His spouse credibly concurs.

16. The Tribunal notes difficult challenges facing our aging citizenry in navigating a myriad of Plan rules and sometimes-predatory practices of a competitive insurance industry.

17. Only after the first charge of increased premium did Petitioner know, understand, and immediately contact a Plan representative who then attempted to complete an Exception Form on his behalf. Ex. 1.

18. An Exception Form is intended to operate as an in-agency appeal and request for exception to Plan rules and regulations.

19. Here the representative noted the "Error Type" as "Member Error" and in the detail indicated the member and spouse "thought they were signing up for a supplement…." *Id*.

20. The consistent contentions of Petitioner are that he only consulted a third-party caller for information and never authorized 'signing up' for anything. Little to no evidence explained obvious contrast between the Exception Process and Petitioner's case.

21. Exhibit 1, the Exception Form, was denied per the "Review Notes" because Petitioner had to request termination "in December to receive a 1/1/2022 effective date."

22. Exhibit 2, the initial letter explaining denial, states retroactive termination could occur only if such request came "prior to 12/31/2021."

23. Exhibit 3, the final interagency appeal, states that since "health benefits were active through February 28, 2022, the Plan cannot refund premiums for January or February."

24. References to *December* and deadline are significant only by virtue of Open Enrollment rules, the rules from which Petitioner sought exception. *See*, Ex. 3, Decision Guide.

25. In short, the agency denied a request for exception from rules, because of those very rules.

26. Notably, an Exception request is at least otherwise timely if submitted … "[w]ithin thirty days of pension deduction or premium payment …." 20 NCAC 12 .0101(a). In this regard, Petitioner was timely.

27. Unreferenced in this proceeding, tucked away, and wholly unconsidered by the agency here, is some further (though *de minimis*) guidance. On the Plan's website at https://www.shpnc.org/hbrs/exceptions-process and titled *Exception Process*, a coverage correction due to something "that is not the fault of the member" is indicated as appropriate.

28. The state presented a mostly textbook documentary presentation, bolstered with credible and informed testimony, in all but two fatal instances.

29. The state provided zero competent evidence of the *data file* or dual coverage, and completely relied on notice documentation from Humana, *sans* competent accompanying testimony; choosing rather to present with multi-leveled hearsay testimony.

30. Issues of notice and particularly duplicative coverage were squarely before the Tribunal.

31. Throughout the course of the hearing, much was made of notice to Petitioner's spouse, but every indication is that none was directed to Petitioner, the subscriber and payor.

32. Petitioner and his spouse credibly indicate receiving numerous Medicare related mailings/solicitations that are routinely discarded. The spouse relies on Petitioner to handle family business to include opening agency mail.

33. Respondent evidenced that the spouse was mailed, and Petitioner would have seen, an insurance card indicating changed coverage, arguing that this should have been sufficient notice, among other things, that premiums were about to increase more than a hundred times. Given the lack of correspondence, content, type size, form, historical context, demographics, etc., the Tribunal very obviously finds this incredible. Ex. 5.

34. In sum, the Tribunal contrasts credible and competent evidence in favor of Petitioner against key, yet missing or incompetent evidence for the agency.

CONCLUSIONS

Burden

1. Petitioner must prove the essential elements of his cause. *Overcash v. N.C. Dep't of Env't & Nat. Res.*, 179 NC App 697, 704, 635 SE2d 442, 447-48 (2000); GS § 150B-25.1(a). Burden of persuasion is by preponderance or "greater weight of the evidence." *Dillingham v. N.C. Dep't of Human Res.*, 132 NC App. 704, 712, 513 SE2d 823, 828 (1999).

2. Petitioner must prove (1) Respondent substantially prejudiced his rights; and (2) exceeded its authority or jurisdiction, acted erroneously, failed to use proper procedure, acted arbitrarily or capriciously, or failed to act as required by law or rule. GS § 150B-23(a).

3. Contrastingly, due regard is allowed "the demonstrated knowledge and expertise of the agency…." GS § 150B-34(a).

4. Here Petitioner carried his burden. To any extent the state attempted to show *contra* or otherwise defend, it failed. *Bertie Cotton Oil Co. v. R. R.*, 183 NC 95, 110 SE 660 (1922) (burden of proof basics, *citing*, 1 Elliott on Evidence, 139).

Evidence

5. Hearsay is subject to discount or disregard. 26 NCAC 03 .0122; GS § 8C-1, Rule 803.

6. "Hearsay within hearsay" can be admissible "if each part…conforms with an exception…." GS § 8C-1, Rule 805. This was not the case here.

7. "Documentary evidence incorporated by reference may be admitted only if the materials so incorporated are available for examination by the parties." 26 NCAC 03 .0122(3); s*ee*, *State v Wood*, 306 NC 510, 516, 294 SE2d 310, 313 (1982) (exception requires the record).

8. The glaring absence of competent evidence of duplicative coverage adds credence to Petitioner's contentions that he never authorized additional coverage. *Halloway v Tyson Foods, Inc*, 193 NC App 542, 668 SE2d 72 (2008) ("deciding which permissible inference to draw from evidentiary circumstances is as much within the fact finder's province as is deciding which of two contradictory witnesses to believe").

Duties

9. "Our courts have been clear that general contractual relationships do not typically rise to the level of fiduciary relationships." *Sykes v. Health Network Solutions, Inc.*, 372 NC 326, 340, 828 SE2d 467, 476 (2019). "[P]arties to a contract do not thereby become each other's fiduciaries; they generally owe no special duty to one another beyond the terms of the contract ...." Branch Banking & Tr. Co. v. Thompson, 107 NC App 53, 61, 418 SE2d 694, 699, *disc. rev. denied*, 332 NC 482, 421 SE2d 350 (1992).

10. Nonetheless, when the agency undertakes to provide notice or assist a Plan member with prescribed rights of appeal, it is obliged to do so reasonably and with reasonable accuracy. *Dalton v. Camp*, 353 NC 647, 651, 548 SE2d 704, 707 (2001) (the nature of some relationships can impose obligation). This is especially true regarding vested retiree benefits. *Lake v. State Health Plan for Teachers and State Employees*, 380 NC 502, 869 SE2d 292 (2022) (vested benefits like these implicate significant member rights and state obligation).

11. Here unreasonable agency errors occurred.

Errors/Arbitrary and Capricious

12. Failing to provide adequate notice *to the subscriber* to be charged an increased premium, regarding a significant change in dependent coverage, is agency error. *Id*. In absence of clear mandate, we decide on considerations of "policy, fairness and common sense." *Peace v. Employment Sec. Comm'n of N. Carolina*, 349 NC 315, 328, 507 SE2d 272, 281 (1998).

13. Further, providing an apparent allowance of exceptions to Plan rules requires clear basis of denial beyond those very rules. Anything less is arbitrary and capricious. *State ex rel. Com'r of Ins. v. North Carolina Rate Bureau*, 300 NC 381, 420, 269 SE2d 547, 573 (2017) (unfairness, uncareful consideration, or flawed reasoning should not be apparent).

14. The Tribunal acknowledges that:

> The "arbitrary or capricious" standard is a difficult one to meet. Administrative agency decisions may be reversed as arbitrary or capricious if they are "patently in bad faith," or "whimsical" in the sense that "they indicate a lack of fair and careful consideration" or "fail to indicate 'any course of reasoning and the exercise of judgment'...." *Comm'r of Ins. v. Rate Bureau*, 300 NC [381] at 420, 269 SE2d [547] at 573 [(1980)] (citations omitted).
>
> *ACT–UP Triangle v. Commission for Health Servs.*, 345 NC 699, 707, 483 SE2d 388, 393 (reciting *Lewis v. NC DHR*, 92 NC App 737, 740, 375 SE2d 712, 714 (1989) (citation omitted)).

15. Nonetheless, agency action undertaken without reference to guiding principles is arbitrary and capricious. *Cape Medical v. NC DHHS*, 162 NC App 14, 24, 590 SE2d 8, 15 (2004). Ignoring one of the few criteria given, and which should have been in play, is comparable.

16. Failure to consider Petitioner's lack of fault here is at least error.

Substantial Prejudice

17. Agency error, and/or arbitrary or capricious conduct, alone or in combination is insufficient; substantial prejudice must also be shown. *Surgical Care Affiliates, LLC v. NC DHHS, Div. of Health Service Regulation, Certificate of Need Section*, 235 NC App 620, 628, 762 SE2d 468, 473-4 (2014) (citations omitted); GS § 150B-23(a).

18. When evidence demonstrates that an Agency did not properly apply its own rules, materiality necessitates such failures "*actually* caused sufficient harm to the petitioner." *Id*.

19. Substantial prejudice is akin to deprivation of property and causing Petitioner to pay fine or civil penalty. GS § 150B-23(a). Here, overcharged premium is sufficiently synonymous.

20. Similarly, wrongly replacing inexpensive spousal coverage, a vested right of this retiree, with inferior and costly coverage substantially prejudiced Petitioner. *Cf.*, *Lake, supra*.

21. Inadequate adherence to regulatory appeals processes also caused substantial prejudice. *Cf.*, *Bowens v. N.C. Dept. of Human Res.*, 710 F2d 1015, 1018 *(*4th Cir 1983*)* (appeal rights created an entitlement for Medicaid service provider); *and*, *Ram v. Heckler*, 792 F.2d 444 (4th Cir 1986) (physician's continued participation in Medicare program is a protected property interest).

22. Petitioner "has the right to require an administrative agency to follow its own rules if its failure to do so would result in a substantial chance that there would be a different result…." *Farlow v. N.C. State Bd. of Chiropractic Examiners*, 76 NC App 202, 208, 332 SE2d 696, 700, *disc. rev. denied*, 314 NC 664, 336 SE2d 621 (1985). Such encourages fair and consistent treatment. *Id*.

23. "[S]ufficiency of the procedures employed must be evaluated in light of the parties, the subject matter, and the circumstances involved." *Farber v. NC Psychology Bd.*, 153 NC App 1, 11, 569 SE2d 287, 295 (2002) (*quoting*, *Presnell v. Pell*, 298 NC 715, 723, 260 SE2d 611, 616 (1979)).

24. The Tribunal "cannot substitute [its] own judgment for that of the Agency if substantial evidence exists" in support. *Total Renal Care of NC, LLC v. NC DHHS*, 171 NC App 734, 739,615 SE2d 81,84 (2005); GS § 150B-34(a); *see*, *NC DENR v Carroll*, 358 NC 649, 660, 599 SE2d 888, 895 (citing cases); *Watkins v. NC State Bd. of Dental Exam'rs*, 358 NC 190, 199, 593 SE2d 764, 769 (2004) (citing cases). The converse is true, particularly when one or more of the feasances are in play; it is the role of OAH to check and address government impropriety. *Id*; GS § 7A-750; GS § 150B-34(a).

25. Given the minimal guidance and criteria provided in the agency appeal process, in essence *insufficiency under the circumstances*, the Tribunal reasonably concludes that any provided has particular significance. Therefore, the Tribunal rules that had the agency properly considered Petitioner's request for Exception, and particularly his lack of fault, he should and would have prevailed; or minimally, he had a substantial chance of prevailing. The agency's failure to follow its own criteria actually caused Petitioner harm.

Final Considerations

26. Nothing in this decision is meant to say that the Plan is a guarantor of health insurance coverage; it is not a safety net against unscrupulous marketing practices. However, neither are such practices excuse for mis-, mal-, or nonfeasance of the Plan.

27. There exists considerable and substantial evidence to justify this ruling of the Tribunal. GS § 150B-51(b)(5), and (c); *see also*, *Sharpe-Johnson v N.C. Dep't of Pub. Instruction*, 280 NC App 74, 80-1, 867 SE2d 188, 192 (2021).

Conclusion

28. In sum, Petitioner successfully contested duplicative coverage, notice, and improprieties in agency appeals processes. Respondent failed to demonstrate (defend) duplicative coverage, proper notice, and/or proper implementation of internal appeals. Each and all of this substantially prejudiced Petitioner and otherwise met the strictures of GS § 150B-23(a).

DECISION

WHEREFORE, Respondent's agency action is **OVERRULED**; Petitioner's demands for refund and reinstatement of spousal health coverage are **ALLOWED.** Respondent will additionally pay Petitioner his filing fee per 26 NCAC 03 .0105(7).

NOTICE OF APPEAL

This is a Final Decision issued under the authority of GS § 150B-34.

Under the provisions of GS § 150B-45, any party wishing to appeal the final decision of the Administrative Law Judge must file 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 written copy of the Administrative Law Judge's Final Decision**. In conformity with the Office of Administrative Hearings' rule, 26 N.C.A.C. 03.0102, and the Rules of Civil Procedure, **this Final Decision was served on the parties as indicated by the attached Certificate of Service**. GS § 150B-46 describes the contents of the Petition and requires service of the Petition on all parties. Under GS § 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 to ensure timely filing.

SO ORDERED.

This the 19th day of December, 2022.

The Honorable Jonathan S. Dills
Administrative Law Judge

CERTIFICATE OF SERVICE

The undersigned certifies that, on the date shown below, the Office of Administrative Hearings sent the foregoing document to the persons named below at the addresses shown below, by electronic service as defined in 26 NCAC 03 .0501(4), or by placing a copy thereof, enclosed in a wrapper addressed to the person to be served, into the custody of the North Carolina Mail Service Center who subsequently will place the foregoing document into an official depository of the United States Postal Service.

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This the 19th day of December, 2022.

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