ATTACHMENT A

THE PROPOSED DECISION

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

In the Matter of the Appeal Regarding the Denial to Change Health Plans of:	Case No. 2016-0537
PATRICIA A. PRANGER,	OAH No. 2016090601
Respondent.	

PROPOSED DECISION

Administrative Law Judge Ed Washington, Office of Administrative Hearings, State of California, heard this matter on December 22, 2016, in Fresno, California.

Senior Staff Counsel Rory J. Coffey represented the California Public Employees' Retirement System (CalPERS).

There was no appearance by or on behalf of respondent Patricia A. Pranger.

Evidence was received, the record was closed, and the matter was submitted for decision on December 22, 2016.

ISSUE

Did CalPERS comply with the terms of the Public Employees' Medical and Hospital Care Act and related regulations when it denied respondent's request to change her health plan outside of the "open enrollment period?"

FACTUAL FINDINGS

1. CalPERS properly served respondent with the Statement of Issues and Notice of Hearing in this matter. The hearing proceeded as a default hearing pursuant to Government Code section 11520.

2. CalPERS is the agency charged with administering the Public Employees' Medical and Hospital Care Act (PEMHCA), pursuant to Government Code section 22750, et

seq. The PEMHCA authorizes and requires the CalPERS Board of Administration (Board) to provide health benefits for state employees, dependents, and annuitants, as well as for employees and annuitants of contracting public agencies that elect to contract with CalPERS for health benefit coverage.

3. As of August 7, 2015, respondent was enrolled in a combination CalPERS Medicare health plan, which included Blue Shield Access Plus. A CalPERS Medicare health plan coordinates benefits between Medicare and CalPERS to reduce participant health premiums and provide additional coverage beyond Medicare.[1] A combination plan exists when at least one family member is enrolled in a CalPERS Medicare health plan and at least one family member is enrolled in a CalPERS Basic health plan.[2]

4. By way of a letter dated August 7, 2015, CalPERS informed respondent that she and her dependents were enrolled in a combination plan that included a CalPERS plan that would no longer provide a Medicare health plan after December 31, 2015. The letter instructed respondent to take the following action:

> **Option 1: If you would like to be enrolled into PERS Choice PPO, administered by Anthem Blue Cross, no action is needed on your part.** CalPERS and Anthem will work together and enroll you and your dependents in a combination plan January 1, 2016, with no lapse in coverage.
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> **Option 2:** If you would like to select another health plan, you may do so during Open Enrollment, which will occur **September 14 – October 9, 2015.** Open Enrollment materials will be mailed to you no later than August 24, 2015, with instructions on how to change your plan.

(Bolding and underlining in original.)

5. On September 9, 2015, CalPERS sent respondent a second letter that contained the same advisory and instructions as the August 7, 2015 letter. Again, the letter specified that respondent's combination plan included a CalPERS plan that was ending and that if she took no action she would be enrolled into PERS Choice PPO as part of her combination plan, or she could select another plan during open enrollment.

6. On September 14, 2015, during the open enrollment period, respondent contacted CalPERS by telephone and requested that her health plan be changed to "PERS Choice." On that same date, CalPERS processed respondent's requested change in health

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[1] CalPERS Medicare Enrollment Guide (Aug. 2016), at page 53.

[2] *Id.*, at page 19.

plan enrollment with an effective date of January 1, 2016, and provided her with written confirmation by mail.

7. On October 19, 2015, CalPERS received a letter from respondent requesting that she be allowed to "revert back to [her] HMO," Blue Shield Access Plus. Respondent explained in this letter that she "made a grave error" when she called and changed her health plan to PERS Choice PPO, because she "neglected to understand that by picking the PPO over an HMO ... [she's] leaving [her] husband with a 20 percent liability for his part of the PPO." Respondent stated in this letter that she and her husband were on a limited income and that the additional 20 percent expense would "ruin [them] financially."

8. By way of a letter dated November 17, 2015, CalPERS denied respondent's request to revert back to her previous plan due to continuity of her health care, because it was "outside of a qualifying event or an open enrollment period." The letter specified that the CalPERS Health Benefit Program was governed by the PEMHCA, which does not permit a health plan change on the basis specified by respondent. The letter also notified respondent that she could file a grievance challenging CalPERS' decision, if she was dissatisfied with its determination.

9. By way of a letter dated December 1, 2015, respondent submitted the following information to CalPERS:

> 1. I'm on Medicare, my husband isn't.
> 2. The previous HMO will no longer service my area.
> 3. I fall into a "hole," due to the above circumstances.
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> I was practically urged to pick PERS Choice during open enrollment. I should have picked PERSCare. It offers 90% coverage versus PERS Choice which is 80% coverage. Please can you help me? I only want for my husband to have as much coverage that I'm afforded.

10. By way of a letter dated February 2, 2016, CalPERS informed respondent that after performing an administrative review of her request to change her health plan outside the annual open enrollment period due to financial hardship, her request was denied. The letter specified that respondent could continue to pursue her appeal through the CalPERS Administrative Hearing Process, if she had new supportive information to provide. The letter also included the following explanation:

> You made an open enrollment plan change on September 4, 2015, to enroll into PERS Choice. The only other option you would have had was to rescind the plan change prior to January 1, 2016, to remain in the health plan you had prior to the open enrollment change. As a Medicare enrollee, you would have had to change to a plan that coordinates with a combination plan

> for Medicare and basic. The only other options to change your health plan outside of open enrollment would be, if you had a change of residence, or if your spouse becomes Medicare eligible.

11. On April 1, 2016, respondent submitted a letter to CalPERS in response to its February 2, 2016 letter. The response included the following statements and questions:

> In the 3rd paragraph [of the February 2, 2016 letter from CalPERS] you state I had until prior to January 1, 2016 to rescind the plan change. In the letter dated December 22, 2015, I tried to rescind the plan change well before the January 1, 2016 date. But, I was not allowed to remain in the same medical coverage I previously had. Why? If the letter dated Feb 2 states I was allowed to do this rescinding; why wasn't I allowed to change my coverage?

12. On April 15, 2016, CalPERS notified respondent in writing that it had received her letter of April 1, 2016. The letter from CalPERS specified that because it had previously addressed respondent's request through the CalPERS' Administrative Review Process, her case was being referred for an administrative hearing.

Discussion

13. Respondent had the burden to present sufficient evidence to establish that she should have been permitted to change her health plan outside of the open enrollment period. The PEMHCA, in conjunction with the PEMHCA regulations, provide several bases for an employee or annuitant to change health plans outside of the open enrollment period. (Cal. Code Regs., tit. 2, § 599.500 et seq.) Respondent did not appear at hearing and did not submit sufficient evidence to meet her burden. Consequently, her appeal is denied.

LEGAL CONCLUSIONS

1. Pursuant to Government Code sections 22760 and 22772, respondent is an employee or annuitant eligible to enroll in an approved health benefit plan, in accordance with the PEMHCA and the regulations of the Board.

2. Government Code section 22790, in pertinent, part provides that "the provisions of the [PEMHCA] shall be administered by the Board. . . ."

3. Government Code section 22841, subdivision (a), provides that "a transfer of enrollment from one health benefit plan to another may be made by an employee or annuitant at times and under conditions as may be prescribed by regulations of the Board."

4. Pursuant to California Code of Regulations, title 2, section 599.502, subdivision (f), an enrolled employee or annuitant may change his or her enrollment, as follows:

> (1)(A) An enrolled employee or annuitant may, prior to, at the time of, or within 60 calendar days after acquiring his or her first eligible family member required to be enrolled, change his or her enrollment to include all family members required to be enrolled.
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> (B) An enrolled employee or annuitant may change his or her enrollment to include all eligible family members required to be enrolled who are acceptable for enrollment under underwriting standards of the carrier if at the time of such change he or she presents a certification of such acceptability from the carrier of the plan in which he or she is enrolled or if such change of enrollment is made during an open enrollment period.
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> (C) A family member who is not enrolled because of other group coverage or because such person is a spouse not living in the employee's or annuitant's household may not thereafter be enrolled as a family member except during an open enrollment period or pursuant to the carrier's certification of acceptability under its underwriting standards.
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> (D) A family member who is a child who has attained the age of 18 and who is not enrolled may not be enrolled except upon return from military service as provided in Section 599.502(f)(2), or pursuant to the carrier's certification of acceptability under underwriting standards, or during an open enrollment period.
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> (E) Notwithstanding any other provision of this subchapter, an employee or annuitant enrolled for self only may enroll a newborn or adopted child provided application for enrollment is received within 60 calendar days of the date of birth or the date physical custody was obtained. The coverage of a newborn or adopted child of an employee or annuitant enrolled for self only begins on the date of birth or the date physical custody is obtained and ends on the last day of that month unless an application to enroll that child is received.
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> (2) An employee or annuitant may at any time change his or her enrollment from self and family to self alone, or delete an eligible family member who is a child who has attained the age

of 18 or enters military service. An employee or annuitant may decrease "family member" enrollment from self and two or more to self and one family member on or after the day on which the last family member in excess of one:

(A) ceases to be a family member;

(B) becomes enrolled in another basic group plan; or

(C) in case of a spouse, ceases to live in his or her household or enters military service.

(D) A spouse whose enrollment is terminated on the basis of ceasing to live in the household may not be enrolled thereafter except during an open enrollment period or pursuant to the carrier's certification of acceptability under its underwriting standards.

(E) A family member who is a spouse or a child who was deleted from an employee's or annuitant's enrollment upon entering military service or was in military service at the time of initial enrollment or at the time he or she became a family member may be enrolled upon return from military service.

(3) Except as described in 599.506(f), when a mandatory change of enrollment results in a retroactive cancellation or deletion of enrollment and creates a difference in premium based on the date a family member became ineligible for coverage and the date an employee or annuitant changed his or her enrollment to delete the ineligible family member, the employer and employee or annuitant may receive a refund. The amount of the refund shall not exceed those excess premiums paid for a period of up to six months prior to the date on which the action is processed and recorded, pursuant to the employee's or annuitant's request for retroactive cancellation or deletion of the ineligible family member.

(4) An employee or annuitant who is not enrolled, but is covered under the Public Employees' Medical and Hospital Care Act and this subchapter by enrollment of a spouse, may enroll in the same plan as was the spouse for self alone or self and eligible family members within 60 calendar days after termination of the spouse's enrollment. An employee who is not enrolled, but is covered by the enrollment of a parent, may enroll in any plan available within 60 calendar days after the termination of

coverage as a family member. An employee or annuitant who is covered by enrollment of another under this subchapter may enroll in the same plan for self alone or self and eligible family members within 60 calendar days after the effective date of a change terminating his or her enrollment.

(5) An employee who is enrolled as an annuitant and whose status as an annuitant terminates, may enroll in the same plan under which he or she was covered as an annuitant, in a manner which will continue coverage.

(6)(A) An employee or annuitant who is enrolled in a plan with a restricted geographic service area and who moves, including all enrolled family members, or changes employment address may, within 31 calendar days before the move and ending 60 calendar days after the move, enroll in another health benefits plan.

(B) An employee or annuitant who is enrolled in a plan with a restricted geographic service area and who moves, and whose enrolled family members do not move, may, within 31 calendar days before the move and ending 60 calendar days after the move, enroll in another health benefits plan.

(C) An employee or annuitant who is enrolled in a plan with a restricted geographic service area and whose enrolled family members move, may within 31 calendar days before the move and ending 60 calendar days after the move, enroll in another health benefits plan.

(D) An employee or annuitant who moves into, or commences employment within, the service area of a plan with a restricted geographic service area may change his or her enrollment to that plan within the period beginning 31 calendar days before and ending 60 calendar days after the move.

(E) An employee or annuitant enrolled in a supplemental plan who moves, other than temporarily, out of the United States as defined in the Federal Social Security Act, may change his or her enrollment to a plan that provides coverage outside the United States.

(7) An employee or annuitant who is enrolled in a health benefits plan which ceases to be an approved health benefits plan may enroll in another plan at any time within 60 calendar

days after the date set by the Board for withdrawal of its approval of the plan.

(8) When an employee or annuitant enrolled for self and family dies, leaving a family member as an annuitant entitled to enrollment in a health benefits plan, the enrollment shall continue by enrollment of the surviving annuitant. The family member annuitant may change or cancel the enrollment providing he or she does so within 60 calendar days of notification of continuation. The effective date of the change or cancellation shall be the first of the month following the death.

(9) For purposes of this subsection (f) and subsection (a) of this section, a change in custody of a child, whether or not accompanied by a change in economic dependency, at the option of the enrolled employee or employees may be considered to terminate or begin eligibility of the child as a family member of the employee or employees affected by the change in custody.

(10) An employee whose enrollment was continued under Section 599.504(b), (c), (d), (e) or (g) may within 60 days of return to pay status make any change in enrollment which he or she could have made had he or she been in pay status during the continuation.

(11) Upon a determination by the Board or the Executive Officer that an employee or annuitant is unable to maintain a satisfactory physician-patient or plan-employee-annuitant relationship, the Board or Executive Officer may permit a change of enrollment to another plan.

(12) An employee may add or delete family members under the provisions of this section during a period of continuation of enrollment under the provisions of Section 599.504.

(13) Enrollment of any person in a supplemental plan may not be changed to enrollment in a basic plan unless there is an involuntary termination of Medicare benefits or as provided in subdivision (f)(6)(E) of this section.

5. To receive the requested health plan change, respondent had to offer sufficient evidence, based upon the rules and regulations of the PEMHCA, to establish that she was entitled to the plan change she sought. Respondent did not appear at hearing and failed to offer such evidence. Consequently, respondent's appeal is denied.

ORDER

Respondent Patricia A. Pranger's appeal of CalPERS' denial of her request to change her health plan outside of the open enrollment period is DENIED.

DATED: January 18, 2017

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Ed Washington
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ED WASHINGTON
Administrative Law Judge
Office of Administrative Hearings