ATTACHMENT A

THE PROPOSED DECISION
In the Matter of the Appeal Regarding Denial of Retroactive Enrollment in CalPERS’s Medicare Health Benefit Plan and Retroactive Reimbursement of Medicare Part B of:

SYLVIA G. GARCIA.

Respondent.

Case No. 2018-1199
OAH No. 2019011114

PROPOSED DECISION

Mary Agnes Matyszewski, Administrative Law Judge, Office of Administrative Hearings, State of California, heard this matter in San Diego, California, on May 2, 2019.

Rory Coffey, Senior Staff Attorney, represented petitioner Robert Jarzombek, Chief, Health Account Management Division, Board of Administration, California Public Employees’ Retirement System (CalPERS), State of California.

Sylvia Garcia, respondent, appeared and represented herself.

On May 2, 2019, the record closed, and the matter was submitted.

ISSUE

Should respondent be allowed retroactive enrollment in CalPERS’s Medicare health benefit plan and retroactive reimbursement of Medicare Part B effective February 1, 2015?

PROTECTIVE ORDER SEALING CONFIDENTIAL RECORDS

Information in Exhibit 20 is subject to a protective order. The exhibit, respondent’s my/CalPERS Health Information, was received and contained confidential information. It is impractical to redact the information from this exhibit. To protect respondent’s privacy and her confidential personal information from inappropriate disclosure, Exhibit 20 was ordered
FACTUAL FINDINGS

Jurisdiction

1. The Public Employees’ Medical and Hospital Care Act (PEMHCA) authorizes and requires CalPERS to provide health benefits to state employees, dependents, annuitants, as well as to employees and annuitants of contracting public agencies which elect to contract with CalPERS for health benefit coverage.

2. Respondent was employed with R.J. Donovan Correctional Facility, California Department of Corrections and Rehabilitation. By virtue of her employment, respondent and her dependents are eligible for CalPERS health benefits under PEMHCA.


4. Respondent asserted that in 2015 she delivered her Medicare enrollment documents to the CalPERS regional office. She believed CalPERS was aware she was enrolled in Medicare, and she requested retroactive enrollment in CalPERS’s Medicare health benefit plan effective February 1, 2015, and retroactive reimbursement for Medicare Part B effective February 1, 2015.

5. CalPERS asserted that, after reviewing its records, there was no indication that respondent submitted Medicare documents prior to May 14, 2018, making her CalPERS’s Medicare health plan coverage effective June 1, 2018, the first day of the month following receipt of her Medicare enrollment documentation. CalPERS asserted respondent is eligible for reimbursement of Medicare Part B payments effective June 1, 2018. CalPERS denied her request for retroactive enrollment in CalPERS’s Medicare health benefit plan effective February 1, 2015, and her request for retroactive reimbursement for Medicare Part B effective February 1, 2015.

6. On June 14, 2018, and September 5, 2018, CalPERS notified respondent of its determination and advised her of her appeal rights.

7. On June 26, 2018, and September 25, 2018, respondent timely appealed CalPERS’s determination and requested an administrative hearing.
8. On January 14, 2019, petitioner signed the Statement of Issues in his official capacity. The statement of issues and jurisdictional documents were served on respondent, who timely appealed, and this hearing followed.

Customer Touch Point Report Entries

9. CalPERS's Customer Touch Point Report (CTP) entries documented all communications between CalPERS staff and respondent.

10. Multiple entries in 2012, 2013, and 2014 documented respondent's calls to CalPERS regarding her disability payments and application, the death of her sister-in-law, and removal of her adult daughter from her health plan.

11. October 2014 entries documented respondent's calls inquiring about health benefits, coverage information, and physicians available under her Blue Shield NetValue health plan.

12. Two December 31, 2014, entries noted that respondent called "about the change in her monthly amount on her warrant. Confirmed it is due to change in health premiums. [Respondent] has additional questions about medicare [sic] enrollment." The call was transferred "to IAA," indicating the call was escalated to a CalPERS specialist in health care issues. The other entry that day documented that respondent called because the "NetValue premium is a financial hardship for her. I let her know we can change her coverage effective 1/1/15 [sic] but she may have to select another doctor. She is worried about that so she will call the doctor to see if they take any of the plans I gave her for her zip code." There was no reference in this second note to any discussions regarding Medicare.

13. January 6, 2015, entries documented calls respondent made regarding changing her plan. She was transferred to a health care specialist and that note documented respondent's request to change from Blue Shield NetValue to another health plan. "Advised member of the health plans available in her zip code. Member is interested in the Sharp plan. Provided phone number and website for Sharp Health Plan." There was no reference to any discussions about Medicare. Other January 2015 notes documented respondent's request to change to Sharp, information regarding the time it would take to make the change, and respondent's inquiry about being reimbursed her January premium "for switching health plan to lesser amount." CalPERS advised respondent there could be no January reimbursement as the Sharp plan was effective February 1, 2015.

14. February 2015 entries documented issues with prescription drug coverage that were "resolved."

15. March 25, 2015, entries noted that respondent "called to inquire about some medicare [sic] questions." Her call was transferred, and the transfer note indicated that respondent "had questions about coordination of Medicare information to CalPERS. member [sic] decided to drop off copy of Medicare card at nearby [regional office]." There
were no notes indicating that respondent actually dropped off any Medicare information at the regional office.

16. The next entries were dated October 22, 2015, and referenced an invoice “that may or may not have been mailed” regarding a health receivable statement and a new statement that was mailed.

17. A July 15, 2016, entry documented respondent’s call “regarding her health plan and medicare [sic]. She stated she signed up for part B [sic] as a supplement. She wants to know why she’s receiving bills from the service she seeks. Explained that we do not have any plans that will allow medicare [sic] to be the supplement. Explained that our plans when she goes on medicare [sic] becomes [sic] the supplement to it. Explained that when she goes on [Plans A and B], she needs to switch her health plan because sharp [sic] does not have a supplement plan.”

18. Several 2017 entries documented direct deposits and paperless statements.

19. A July 5, 2017, entry noted that respondent called regarding “health. Referred [respondent] to Sharp and medicare [sic] to request new insurance cards.”

20. A May 8, 2018, entry noted that respondent came to the regional office to “discuss available health benefits and premiums for retirees and dependents. [Respondent] made no changes to health plan at this time.”

21. On May 14, 2018, respondent came to the regional office to submit a Medicare Certification form for her spouse. The note documented that respondent “stated she is on Medicare, however has not certified as she was unaware she had too [sic]. Advised to submit Medicare Card and Certification ASAP. [Respondent] would like to be contacted to discuss how a delayed certification may affect her and if her Medicare reimbursement can be retroactive?”

22. On May 16, 2018, CalPERS enrolled respondent in Medicare effective June 1, 2018. Respondent “states she submitted documents to area office a couple of years ago, but no note indicates this.” Her appeal rights for an earlier effective date were explained to her.

23. On May 17, 2018, respondent walked into the regional office and submitted two letters from Medicare regarding her monthly disability benefits. She advised she may file an appeal for an earlier enrollment date.

24. Subsequent 2018 entries documented the appeals process.

25. At this hearing respondent testified that at the end of March 2019 she called CalPERS asking if they had any evidence that she had provided CalPERS with her Medicare information before 2018. Respondent claimed the woman on the phone told her that the
records showed that respondent’s “file was updated in April 2015 showing that you have Medicare.” There are no CTP entries in April 2015 to substantiate respondent’s claims.

26. In response to respondent’s testimony, complainant’s request for a brief continuance was granted so that the most recent CTPs and CalPERS’s health information statements could be emailed to the hearing office. Those records were marked and received in evidence and were current as of May 2, 2019. There was no March 2019 CTP entry or any CTP entries documenting a telephone call. The only CTP entries were ones documenting referral of this appeal to the Legal Department and two calls from respondent, neither of which corroborated her testimony.

27. A January 28, 2019, entry indicated that respondent called “because she received two calls, and no one said anything on the line when she answered. Advised [respondent] there are no notes in the file from today as of yet. Advised [respondent] they will most likely try to reach her again before they note account.”

28. On February 11, 2019, respondent called with “questions about her Medicare enrollment.” She said she submitted her Medicare card in 2015 at the regional office. However, CalPERS told her that “proof of Medicare enrollment was not received at that time.” The February 2, 2015, notes showed she walked into the regional office, but “it was in regards to prescription coverage not Medicare enrollment.” Respondent asserted that she submitted proof of Medicare coverage at the regional office. However, the March 25, 2015, note “indicated that she would submit proof but there are no further notes from [the regional office] indicating she actually went back and submitted proof. Also advised [respondent] there were no incoming documents imaged to her file at that time.”

29. The Health Information documented that CalPERS received respondent’s Medicare information on May 16, 2018.

Annual Health Plan Statements

30. On September 1, 2015, CalPERS sent respondent her 2015 Health Plan Statement documenting that she was enrolled in Sharp Performance Plus California and identifying the covered individuals on the health plan. The statement further advised:

Please review your 2015 health plan statement and 2016 health plan of premium rates to confirm that the information listed is correct. It is your responsibility to be aware of your premium rate and to ensure that it is accurate. If the data are not accurate, please immediately report errors your Health Benefits Officer. If you fail to report changes in a timely manner, you may be liable for the reimbursement of health premiums or healthcare services incurred during the entire ineligibility period. [Bold in original.]
31. On September 1, 2016, CalPERS sent Ms. Garcia her 2016 Health Plan Statement documenting that she was enrolled in Sharp Performance Plus California and identifying the covered individuals on the health plan. That statement further advised:

Please review your customized health plan statement. This information provides your 2016 and 2017 premium rates, enrolled dependents, and specific health benefit changes that may impact you in 2017. You are responsible for ensuring the health enrollment information about you and your dependents is accurate. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or healthcare services incurred during the entire ineligibility period. [Bold in original.]

32. On September 1, 2017, CalPERS sent Ms. Garcia her 2017 Health Plan Statement documenting that she was enrolled in Sharp Performance Plus and identifying the covered individuals on the health plan. The statement further advised:

Please review your customized health plan statement. This information provides your 2017 and 2018 monthly premium rates, enrolled dependents, and specific health benefit changes that may impact you in 2018. You can also access the information online through my/CalPERS at my.CalPERS.ca.gov. You are responsible for ensuring the health enrollment information about you and your dependents is accurate. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or healthcare services incurred during the entire ineligibility period. [Bold in original.]

33. On September 1, 2018, CalPERS staff sent Ms. Garcia her 2018 Health Plan Statement documenting that she was enrolled in United Healthcare Medicare Advantage and identifying the covered individuals on the health plan. The statement further advised:

Please review your health plan statement. This information provides your 2018 and 2019 monthly premium rates, and enrolled dependents, and specific health benefit changes that may impact you in 2018. You can also access this information online through my/CalPERS at my.calpers.ca.gov. You are responsible for ensuring the health enrollment information about you and your dependents is accurate. If you fail to maintain current and accurate health enrollment information, you may be liable for the reimbursement of health premiums or healthcare services incurred during the entire ineligibility period. [Bold in original.]
34. On February 1, 2018, CalPERS sent respondent a letter “regarding Medicare eligibility and enrollment requirements to continue your CalPERS health coverage.” The letter advised that CalPERS records indicated that respondent would soon be turning age 65 and may be eligible for Medicare. The letter instructed her to contact the Social Security Administration to determine her eligibility and provided the “requirements and actions you need to take to continue your CalPERS health coverage.” The letter further advised that California law prohibits retirees and their dependents who are eligible for Medicare Parts A and B from enrollment in a CalPERS basic health benefit plan. “Medicare-eligible members must enroll in Part A if they can do so without cost, enroll in and pay for Part B premiums, and transfer to a CalPERS Medicare health benefit plan to continue their health coverage.” The letter provided additional information, including how to enroll in Medicare, information for eligibility for spouses, and the Medicare Certification form or Ineligibility for Medicare Certification form that must be filed with CalPERS.

The letter contained a section entitled “What are my Medicare health plan options?” It then asked whether respondent was enrolled in one of seven health benefit plans and added that, if so, she had two options. Respondent’s first option was to take no action, in which case CalPERS would enroll her in the United Healthcare (UHC) Group Medicare Advantage PPO Plan (Health Only); if she was outside UHC’s zip code areas, she would be enrolled in PERS Choice Medicare Supplement PPO Plan. Respondent’s second option was to choose one of six plans offered by Anthem, Kaiser, PERS or UHC. If respondent was not Medicare eligible she could choose to stay in the corresponding Medicare health plan of her current health carrier or she could change her plan to one of the six plans offered by Anthem, Kaiser, PERS or UHC.

35. On May 1, 2018, CalPERS sent respondent a letter advising of “a recent change in your health enrollment” with an effective date of June 1, 2018. The letter noted that she was now enrolled in United Healthcare Group HMO and Medicare Advantage PPO - State and Delta PPO Plus Premier. The letter noted that respondent was “Enrolled in Basic” coverage, and her spouse was “Enrolled in Supplemental/Managed Medicare” which was a “Coverage Change.”

36. On May 14, 2018, CalPERS received a Certification of Medicare Status for respondent’s spouse advising that he wished to be enrolled in the “United/Healthcare/Signature Value Allowance.” Attached was a copy of his Medicare health insurance card showing an effective date of June 1, 2018. Also attached was a Social Security Administration Retirement, Survivors and Disability Insurance, Notice of Award, dated February 15, 2015, advising respondent that she was “entitled to monthly disability benefits beginning March 2012.” The Social Security Administration letter also stated, “We found that you became disabled under our rules on September 29, 2011. The date we found you became disabled is different from the date you gave us on the application. To qualify for disability benefits you must be disabled for five full calendar months in a row. The first month you are entitled to benefits is March 2012.” The Social Security Administration letter
contained a section entitled “Information about Medicare” and advised respondent that Medicare Part A (hospital insurance) started March 2014 and Part B (medical insurance) would start February 2015. If respondent wanted these benefits to start earlier, she could choose medical insurance benefits beginning March 2014 by notifying Social Security Administration in writing and paying a fee.

37. On May 16, 2018, CalPERS sent respondent a letter identifying her health plan as United Healthcare Group Medicare Advantage PPO - State and Delta PPO Plus Premier. She was “Enrolled in Supplemental/Managed Healthcare” which was a “Coverage Change.”

38. On June 5, 2018, CalPERS received respondent’s letter advising that she was “granted a social security case in February 2015” and noting her effective dates for Parts A and B. Respondent wrote:

I called Calpers [sic] in those years in re-guards [sic] to my medi-care [sic] card I received, and was instructed per telephone to bring in the medi-care [sic] card, they needed a photocopy of it. I complied, but I was never told or explained that medi-care [sic] was to be my primary insurance and the state insurance of my choosing would be my secondary, so for the past four years I have had Blue Shield and then change [sic] to Sharp HMO. I never received notification that medi-care [sic] was to be my primary. In which this change [sic] should have been made when I complied and went into the offices of San Diego CALPERS [sic] and gave my medicare [sic] card and a copy was made.

I received notification that my dependent my husband [name] was reaching 65 years old and he had to go primary medi-care [sic] and then Calpers [sic] insurance we chose United Alliance for him. We went into the offices in San Diego to do the change. At that time I was advised that because of his change in [sic] me being the primary person on medical insurance that I needed to change medi-care [sic] as my primary also. And that I should have done this in 2014. I said that I did not know this I was never informed or educated on the matter.

Then I received a call on May 16th from a representative from Calpers [sic] enrolling me into the same insurance United healthcare [sic] the secondary, and medicare [sic] the primary effective June 1st 2018. I then questioned everything of [sic] not being informed and the representative stated to me that she couldn’t help me only thing [sic] she could assist me in was to put the effective date of June 1st 2018 and if I wanted to appeal the effective date I needed to put it in writing and send my
request to the Health Benefits Division which I am doing now. I went into the offices of Calpers today May 17, 2018 informing that I was going to appeal. I’m appealing my effective date for my medical insurance, to go back of when I was supposed to originally have had medicare as my primary and my calpers insurance as my secondary and requesting any retroactive moneys that are due to me I am requesting that it will be released to me.

Respondent attached a copy of the February 15, 2015, Social Security Administration Notice of Award, as well as a May 15, 2018, Social Security Administration letter that stated: “You asked us for information from your record. The information that you requested is shown below.” The letter noted the amount of respondent’s Social Security benefits beginning December 2017 and her monthly Social Security payment after her monthly medical insurance premiums of $134 were deducted.

39. On June 14, 2018, CalPERS sent respondent a letter thanking her for her June 5, 2018, request for a retroactive enrollment effective date in a California Public Employees’ Retirement System (CalPERS) health benefits plan.” CalPERS advised that its health program is governed by PEMHCA, and the regulations provide that “the effective date of enrollment shall be the date Medicare coverage became effective or the first of the month following receipt of the application, whichever is later.” CalPERS advised: “After a careful review of your account, your enrollment documents were received on May 16, 2018. Pursuant to [the regulations] the effective date of your CalPERS health coverage is June 1, 2018. Your request for a retroactive enrollment effective February 1, 2015 is denied.” [Emphases in original.] CalPERS informed respondent of her right to appeal.

40. On July 2, 2018, CalPERS received respondent’s letter of appeal in which she wrote:

I was granted an effective date for Medicare Part b for medical insurance as of February 2015. My chief complaint is that I am requesting due retroactive premiums due to me as of my effective date of February 2015.

As I before I stated I had no knowledge or letters of information that Medicare was to be my primary insurance as of that effective date. And CalPERS insurance was to be my secondary insurance I was never notified even when I called CalPERS in San Diego, I was just informed to bring in a copy of my Medicare insurance card.
Please see my previous certified letter to your office. If I would have been notified at the time I would have made appropriate changes. I did not because I had no knowledge of the matter. If I would have known I would have made the changes immediately of [sic] Medicare being my primary insurance and CalPERS being my secondary.

I am requesting retroactive premiums that were paid from my [sic] effective date of February 2015 - to present.

41. On September 5, 2018, CalPERS sent respondent a letter acknowledging her appeal. CalPERS referenced PEMHCA, the applicable Government Code sections and the regulations. CalPERS advised that it had "performed an administrative review regarding your request to change the effective date of your enrollment" and "cannot approve your request." CalPERS's decision was based on the regulations which set forth the effective dates of enrollment. CalPERS's system contained the following relevant entries. On January 6, 2015, respondent contacted CalPERS to change her health plan from Blue Shield NetValue to Sharp HMO basic health plan. On January 7, 2015, she was enrolled in the Sharp plan as requested, effective February 1, 2015. On May 16, 2018, CalPERS received her request to enroll in a Medicare health plan; therefore the effective date of that health plan would be June 1, 2018. Reimbursement for Medicare premiums apply to eligible members enrolled in a Medicare health plan making the effective date of respondent's reimbursement also June 1, 2018. CalPERS further advised:

Medicare Advantage plans are regulated by the Centers for Medicare and Medicaid services (CMS). A retroactive enrollment request in a Medicare Advantage plan must meet CMS requirements and must be submitted to CMS for approval. Our records reflect that you were eligible for Medicare coverage prior to June 1, 2018 but do not reflect that you requested enrollment in a Medicare health plan sponsored by CalPERS employer group health plan [sic] prior to May 16, 2018. Our records do not substantiate retroactive enrollment in a Medicare health plan and retroactive reimbursement for Medicare Part B premiums pursuant to California law.

CalPERS advised respondent of her appeal rights.

42. On September 25, 2018, respondent sent the CalPERS Board of Administration a letter, which it received on October 1, 2018, requesting a formal hearing. In that letter respondent noted that she was "granted Medicare at the age 56 (Three years ago)." On January 6, 2015, during open enrollment, she "contacted CalPERS to make the necessary changes to a more economical health plan on premiums [sic]" and changed from

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1 Presumably, respondent was referring to her June 5, 2018, letter to CalPERS.
Blue Shield to Sharp effective February 1, 2015, to “give me savings on premium [sic].” Respondent received her Medicare card effective February 2015 and brought it into CalPERS’s offices “to have a copy made for your files. At which time I was never informed too [sic] change Medicare as my Primary insurance which would have been a substantial amount of saving on premiums for my primary insurance. The proper change was not made to reflect Medicare as my primary insurance. It was not managed properly, resulting in over pay in [sic] my part.”

Witness Testimony

43. Cynthia Martinez, Associate Governmental Program Analyst, CalPERS Medicare Administration Unit, is responsible for processing members’ Medicare enrollment in CalPERS medical health benefit plans. She explained the laws governing Medicare and health plan enrollments for CalPERS members and authenticated CalPERS’s records received in evidence. Ms. Martinez also explained that eligibility for Medicare Part B occurs if a person turns 65 or if a person is determined to be disabled. In the former case, CalPERS automatically sends letters to members about Medicare and has the authority to enroll members in Medicare Parts A and B. Members under age 65 who are determined by the Social Security Administration to be eligible must notify CalPERS of that determination. CalPERS has no other way of obtaining that information because the Social Security Administration does not notify CalPERS of those determinations.

Ms. Martinez reviewed respondent’s file and CalPERS’s records, and there were no indications that respondent ever notified CalPERS of her Medicare eligibility before May 2018. Moreover, had respondent notified CalPERS in 2015, as she claims, she would not have been able to remain enrolled in her Sharp health plan because that plan was not an option for members receiving Medicare. If respondent had given her Medicare card to CalPERS in 2015, CalPERS would have notified respondent that she needed to change her health care plan, something that was not done. Moreover, respondent received her yearly Health Plan Statements, which never stated that she was receiving Medicare until her 2018 statement after CalPERS learned of the Medicare eligibility. It was respondent’s duty to review those yearly statements to confirm that the health care plan identified is correct. Respondent never notified CalPERS before 2018 that she was receiving Medicare.

Contrary to respondent’s claim that CalPERS staff told her in a March 2019 phone call that her file had been “updated in April 2015,” Ms. Martinez found no such “update.” CalPERS cannot process Medicare enrollment for persons under age 65 without the documents showing eligibility and CalPERS never received those records from respondent until May 2018.

44. Ms. Garcia testified that she is a retired case records analyst and is thus familiar with record keeping. She also knows the importance of contacting CalPERS, and the CTP shows her numerous contacts with CalPERS.
Respondent was aware she needed to notify CalPERS of her Medicare eligibility determination, and she brought her Medicare card to the regional office some time in 2015. Her husband drove her as she was still not driving due to her injury. When she arrived at the regional office, respondent gave her Medicare card to the person at the window, who left to copy it and told her that was all she needed to do.

After that 2015 visit, respondent assumed CalPERS knew of her Medicare enrollment and that it was a "supplement" to her other health insurance. All the time she was enrolled in Sharp, she thought CalPERS knew of her Medicare enrollment. Even when her husband became Medicare eligible, she still thought her Medicare was a supplement to her Sharp plan. It was not until she spoke with CalPERS staff in 2018, when she and her husband were providing his Medicare certification, that respondent learned that Medicare had to be her primary insurance. However, 2018 was not the first time she told CalPERS she was Medicare eligible, and she thought they had a copy of her Medicare card that she provided in 2015 at the regional office. Respondent was shocked to discover CalPERS did not have it; she was never aware CalPERS did not know she was determined to be Medicare eligible in 2015.

Further, during respondent's March 2019 call to CalPERS seeking any records that showed she delivered her Medicare card in 2015, the CalPERS person on the phone said her file had been "updated in April 2015." This date corresponds to the timeframe when respondent went to the CalPERS' regional office with her Medicare card. Respondent made the call on the car's speaker phone while driving with her husband, and, according to respondent, he could confirm the conversation she had with CalPERS.

On cross-examination, when asked about her yearly Health Plan Statements, respondent testified she "glanced over" them. She thought they merely reiterated the fact that she was enrolled in a health plan. Those statements confirmed her understanding that Medicare was the "supplement" to the health insurance plan listed on the yearly statements. Respondent also acknowledged that she only gave CalPERS her Medicare card in 2015, not the Social Security Administration letter or a Medicare certification; CalPERS told her they only needed her Medicare card. Respondent was unaware she needed to file a certification.

45. Mr. Garcia testified he took his wife to the regional office where she delivered her Medicare card. She handed her card to "the man" who told them to wait. The man left, returned, and gave respondent's Medicare card back to her. Respondent and Mr. Garcia then left. CalPERS never asked his wife to provide a Medicare certification. Mr. Garcia recalled the recent speakerphone call in the car. His wife called CalPERS requesting documents for her upcoming hearing and was placed on hold for a long time. However, when asked about the substance of the conversation, Mr. Garcia testified he could not recall what was said.
LEGAL CONCLUSIONS

Burden and Standard of Proof

1. An applicant for retirement benefits has the burden of proving by a preponderance of the evidence that he or she is entitled to it. (Greatorex v. Board of Administration (1979) 91 Cal.App.3d 54).

2. In the absence of a statute to the contrary, the standard of proof is a preponderance of the evidence. (Evid. Code, § 115.)

Jurisdiction

3. CalPERS's Health Program is governed by the Public Employees' Medical and Hospital Care Act (PEMHCA) commencing with Government Code section 22750 et seq. and implemented through California Code of Regulations, title 2.

Applicable Code Sections

4. Government Code section 22750 states: "This part may be cited as the Public Employees' Medical and Hospital Care Act. As used in any contract or statute, the term 'Meyers-Geddes State Employees’ Medical and Hospital Care Act' shall be construed to refer to and mean the Public Employees’ Medical and Hospital Care Act."

5. Government Code section 22775 defines family member to include an employee's spouse.

6. Government Code section 22777 defines a health benefit plan as "any program or entity that provides, arranges, pays for, or reimburses the cost of health benefits."

7. Government Code section 22794 gives the board "all powers reasonably necessary to carry out the authority and responsibilities expressly granted or imposed upon it under this part."

8. Government Code section 22800 states:

   (a) An employee or annuitant is eligible to enroll in an approved health benefit plan, in accordance with this part and the regulations of the board.

   (b) Regulations may provide for the exclusion of employees on the basis of the nature, conditions, and type of their employment, including, but not limited to, short-term appointments, seasonal or intermittent employment, and employment of a like nature. However, no employee may be
excluded solely on the basis of the hazardous nature of the employment.

9. Government Code section 22844 states:

(a) Employees, annuitants, and family members who become eligible to enroll on or after January 1, 1985, in Part A and Part B of Medicare shall not be enrolled in a basic health benefit plan. If the employee, annuitant, or family member is enrolled in Part A and Part B of Medicare, he or she may enroll in a Medicare health benefit plan.

(b) Employees, annuitants, and family members enrolled in a prescription drug plan under Part D of Medicare shall not be enrolled in a board-approved health benefit plan. This subdivision does not apply to an individual enrolled in a board-approved or offered health benefit plan that provides a prescription drug plan or qualified prescription drug coverage under Part D of Medicare as part of its benefit design.

(c) This section does not apply to employees and family members that are specifically excluded from enrollment in a Medicare health benefit plan by federal law or federal regulation.

(d) The board shall not grant any further exemptions to this section after July 1, 2015.

10. Government Code section 22848 authorizes an employee who is dissatisfied with any action or failure to act in connection with his or her coverage or the coverage of his or her family members shall have the right to appeal to the board and shall be accorded an opportunity for a fair hearing.

11. Government Code section 22879 states in part:

(a) The board shall pay monthly to an employee or annuitant who is enrolled in, or whose family member is enrolled in, a Medicare health benefit plan under this part the amount of the Medicare Part B premiums, exclusive of penalties, except as provided in Section 22831. This payment may not exceed the difference between the maximum employer contribution and the amount contributed by the employer toward the cost of premiums for the health benefit plan in which the employee or annuitant and his or her family members are enrolled. No
payment may be made in any month if the difference is less than one dollar ($1).

(b) This section shall be applicable only to state employees, annuitants who retired while state employees, and the family members of those persons.

Applicable Regulations

12. California Code of Regulations, title 2, section 599.503, states:

(a) Normal Effective Date. The effective date of enrollment, re-enrollment, or change of enrollment shall be the first of the month following the date the employee or annuitant's Health Benefits Plan Enrollment Form is received in the employing office, subject to deferral under subsection (b) of this section. An enrollment shall not become effective if payroll deduction is not accomplished within six months following the date on which such enrollment would normally have become effective.

(b) Deferred Effective Date. The effective date of enrollment of an employee or annuitant who, in the month preceding that in which his or her enrollment would otherwise be effective, has insufficient earnings after all other mandatory deductions to permit deduction of his or her full contributions, shall be the first day of the month following that in which his or her earnings after other mandatory deductions are sufficient to permit such deduction. This applies to an employee hired on the last day of the month which is also the first day of a pay period.

(c) Effective Date of Enrollment by Certification of Acceptability. The effective date of enrollment, re-enrollment or change of enrollment for an employee or annuitant with respect to whom a certification of acceptability is received by his or her employing office shall be the first day of the following month subject to deferral under subsection (b) of this section.

(e) Effective Date of Enrollment of an Annuitant on Approval of Retirement. The effective date of enrollment of an annuitant under Section 599.502(d)(3) is the first of the month following the month in which retirement is approved, but in no event
earlier than the first day of the month following the effective
date of retirement.

(f) Effective Date of Enrollment of an Eligible Family Member
(other than an adopted or newborn child). The effective date of
a change of enrollment adding an eligible family member, other
than an adopted or a newborn child, shall be the first of the
month following the date the Health Benefits Plan Enrollment
Form is received in the employing office. Enrollment of an
eligible family member may not be earlier than the first day of
the month following the acquisition of the family member.

(g) Contracting Agency Employees and Annuitants.
Enrollments of a contracting agency’s employees and annuitants
which are received in the office of the Board on or before the
last day of the month immediately preceding the effective date
of the agency’s participation under the Act shall be effective on
the effective date of such agency participation.

(i) Effective Date in Open Enrollment Period. The effective
date of enrollment in special or limited open enrollment period
shall be fixed by the Board in its action providing such open
enrollment period.

13. California Code of Regulations, title 2, section 559.517, subdivision (e), states:
Enrollment in a Supplemental Plan. (1) Post-1997 Basic Health
Plan Enrollees, Post-2000 CSU Basic Health Plan Enrollees,
and Prospective Medicare Beneficiaries who are Medicare-eligible may enroll in a Medicare Plan by submitting an
application to the Board and proof of enrollment in Parts A and
B of Medicare. Enrollment in the Medicare Plan shall be
effective on the date Medicare coverage became effective or the
first of the month following receipt of the application,
whichever is later.

Evaluation

14. Respondent did not establish by a preponderance of the evidence that she
notified CalPERS about her Medicare eligibility before 2018. None of the documents
introduced into evidence supported her testimony that she provided that information to
CalPERS in 2015 or that her file had been “updated” with that information in April 2015. If
she had given her Medicare card to CalPERS’s regional office staff in 2015, this would have
caused CalPERS to notify respondent of the need to change her health plan because Sharp
did not provide Medicare coverage. There was, however, no evidence presented that CalPERS ever notified respondent of the need to change her insurance because of her Medicare coverage until 2018. More importantly, from 2015 through 2017 respondent received yearly Health Plan Statements advising her of her health coverage. None of those statements listed Medicare, and this put respondent on notice that CalPERS had no information that she was Medicare eligible. As those statements noted in bold lettering, it was respondent’s duty to ensure the accuracy of the information contained therein.

A preponderance of the evidence established that the first time CalPERS received notice that respondent was enrolled in Medicare was May 2018. Thereafter, CalPERS properly determined that respondent’s CalPERS’s Medicare health plan coverage was effective June 1, 2018, and that she was eligible for reimbursement of Medicare Part B payments effective that same date. CalPERS properly denied Ms. Garcia’s requests for retroactive enrollment in CalPERS’s Medicare health benefit plan and retroactive reimbursement of Medicare Part B, effective February 1, 2015.

ORDER

Sylvia Garcia’s appeal is denied. CalPERS shall not retroactively enroll her in a CalPERS’s Medicare health benefit plan effective February 1, 2015. CalPERS shall not retroactively reimburse her for Medicare Part B premium payments effective February 1, 2015. Ms. Garcia’s CalPERS’s Medicare health plan coverage was effective June 1, 2018, and she is eligible for reimbursement of Medicare Part B payments effective June 1, 2018.

DATED: May 31, 2019

Donald P. Cole
DONALD P. COLE for
MARY AGNES MATYSZEWSKI
Administrative Law Judge
Office of Administrative Hearings