STATE OF FLORIDA
DIVISION OF ADMINISTRATIVE HEARINGS

DONNA KRYSA-MCVAY,

Petitioner,

vs. Case No. 16-3254

DEPARTMENT OF MANAGEMENT
SERVICES, DIVISION OF STATE
GROUP INSURANCE,

Respondent.
_______________________________/

RECOMMENDED ORDER

Pursuant to notice, a final hearing was conducted in this case on November 29, 2016, in Tallahassee, Florida, before Administrative Law Judge June C. McKinney of the Division of Administrative Hearings.

APPEARANCES

For Petitioner: Paul D. Edwards, Esquire
104 Southeast 8th Avenue
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For Respondent: Gavin D. Burgess, Esquire
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Department of Management Services
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STATEMENT OF THE ISSUES

Whether the Respondent is responsible to cover Petitioner's husband's medical claims as the primary payer from May 1, 2015,

through July 1, 2016; and, if so, the amount Respondent would be required to cover.

PRELIMINARY STATEMENT

By letter dated August 21, 2015, Department of Management Services, Division of State Group Insurance ("DSGI" or "Respondent"), notified Petitioner of its Level II denial of Petitioner's request to postpone Respondent's status change to secondary payer until Medicare Part B became effective on July 1, 2016. Petitioner filed a timely Petition contesting the denial. Subsequently, the case was referred to the Division of Administrative Hearings ("DOAH"). Pursuant to notice, a final hearing proceeded as scheduled on November 29, 2016.

At the final hearing, Petitioner testified on her own behalf and called her husband as a witness, Gary McVay ("G.M." or "Husband"). Petitioner's Exhibits numbered 1, 3, 11, and 12 were admitted into evidence. Respondent presented the testimony of two witnesses: Kathy Flippo and Jessica Bonin. Respondent's Exhibits numbered 1, 3 through 6, 8 through 14, and 18 were admitted into evidence.

The parties did not order a transcript of the hearing. The parties availed themselves of the right to submit proposed recommended orders 20 days after the final hearing. Both parties filed timely Proposed Recommended Orders, which have been considered in the preparation of this Recommended Order.

FINDINGS OF FACT

1. In 1976, Petitioner became employed with the State of Florida.

2. Since 1995, Petitioner and G.M. were insured under the State Employee's PPO Plan ("PPO Plan").

3. As a primary payer, the PPO Plan paid 100 percent of all claims incurred, subject to the payment schedule set forth in the PPO Plan.

4. In 2007, G.M. became Medicare-eligible due to a disability. On October 1, 2007, he enrolled in Medicare Part A and Medicare Part B.

5. On November 30, 2007, although he was eligible for Medicare Part B, Husband deferred enrollment in Medicare Part B and terminated Medicare Part B.

6. On December 31, 2012, Petitioner retired from her employment with the State of Florida.

7. During her employment and after retirement, Petitioner received the annual Group Health Insurance Plan Booklet and Benefits Document booklets detailing the PPO Plan. Petitioner did not review the eligibility requirements for Medicaid Part B until 2015.

8. The PPO Plans that were mailed to Petitioner in 2007, 2012, and 2015 all contained identical language on page 13-2, which stated "If the disabled dependent is your

spouse, your spouse's coverage under this Plan will continue to be primary, paying benefits first, as long as you are an active employee."

9. The PPO Plan coordination of benefits provision designates DSGI as the primary payer, which pays 100 percent of the benefits for a retiree or her spouse until the retiree or spouse becomes eligible for Medicare Part B. Once the retiree or spouse becomes Medicare-eligible, DSGI becomes the secondary payer and pays 20 percent of benefits, as Medicare-eligible participants are entitled to have 80 percent of their expenses covered by Medicare Part B. The PPO Plan also provides that DSGI will be the secondary payer even if the retiree or spouse is not enrolled in Medicare Part B.

10. Petitioner and G.M. looked at plans annually during open enrollment. They needed health insurance because of G.M.'s health problems. Petitioner would call People First annually to confirm continuance of the PPO Plan because the McVays did not want to be changed to an HMO.

11. From January 1, 2013, to May 1, 2015, Petitioner paid full premiums, which Respondent accepted, and Respondent paid all claims in full as the primary payer. In reliance on this coverage and the representation of Respondent through its actions and inactions, G.M. continued to defer his coverage through Medicare Part B.

12. DSGI contracts Florida Blue as a third-party administrator.

13. Florida Blue conducted a routine audit and discovered the error that Medicare Part B should have been the primary payer for Husband not Respondent. Husband's disability status had slipped through the system when Petitioner retired.

14. On April 13, 2015, Florida Blue notified DSGI by email that G.M. was eligible for Medicare Part B due to disability.

15. On or about April 30, 2015, Florida Blue notified Petitioner by letter of DSGI's intent to assume secondary payer status. The letter provided the audit results and stated:

> During a recent audit it was discovered that your h[u]sband is enrolled in Medicare Parts A & B and have been for quite some time. Therefore, Medicare should pay your claims as primary and your retiree health coverage will be your secondary coverage. Your current insurance premium will be reduced by $407.16 per month effective May 1, 2015, as described below.
>
> You are also due a refund of premium however you can only receive a refund for two years of overpayments.

16. DSGI switched to secondary payer status and changed G.M.'s benefit level to Medicare II tier, effective May 1, 2015.

17. Upon Respondent's discovery that Husband was Medicare-eligible, Respondent prospectively applied the coordination of benefits provision of the PPO Plan. The adjustment reduced Petitioner's premium payment to correspond with Respondent's

status as a secondary payer. Additionally, Respondent refunded all amounts that Petitioner overpaid as a result of previously scheduled automatic deductions.

18. As a secondary payer, the PPO Plan pays only 20 percent of all claims incurred.

19. Upon DSGI's switch from primary payer, Petitioner and G.M. attempted to obtain Medicare Part B for G.M. but were not able to do so until the open enrollment period.

20. As a result, G.M. was exposed to paying 80 percent of all claims that would have otherwise been paid by Medicare had he been enrolled in Medicare Part B.

21. Petitioner and G.M. would have made alternative arrangements for health insurance coverage had they been informed that G.M.'s status would change their primary payer and they would have a lapse in coverage.

22. Petitioner and Husband went to the Social Security Office several times in an attempt to get special enrollment but were unable to obtain coverage.

23. Respondent's decision to drop coverage is not considered a qualifying event by Medicare for special enrollment.

24. Petitioner and Husband also sought private brokers for coverage, but were not able to obtain insurance.

25. For 14 months, May 1, 2015, through July 1, 2016, G.M. did not have a primary payer, only the PPO Plan as a secondary payer.

26. In January 2016, Husband was able to enroll in Medicare Part B during open enrollment with coverage beginning on July 1, 2016.

27. During the time G.M. was uncovered, he had several medical incidents, which incurred medical expenses.

28. On April 4, 2016, the EMT transported Husband to the hospital after his defibrillator went off.

29. Husband also was hospitalized at Aventura Hospital and Medical Center from December 22 through 24, 2015, when blood was seeping into his bone fracture of his left ankle.

30. Husband received health statements ("statements"), Petitioner's Exhibit 12, from Florida Blue summarizing his medical expenses. Each statement contains the language in all capital letters "THIS IS NOT A BILL."

31. The statements to which the Medicare primary was denied also provided language "Resubmit with EOMB."

32. The statements, which indicated a network provider was utilized, also stated, "Therefore no patient responsibility."

33. For the December 2015 hospital stay, claim 8288, the billing statement designates $30,402.03 is owed. However, the

statement provides Medicare had not processed the claim. It also states "THIS IS NOT A BILL."

34. Each statement also designated out-of-pocket amounts of $0.00 or indicated that a network provider was used and eliminated member debt by stating "no patient responsibility."

35. Petitioner appealed Respondent's decision to terminate Husband's coverage. She seeks reimbursement for medical expenses G.M. incurred during the 14-month period when the PPO Plan was the secondary payer and G.M. was not enrolled in Medicare Part B from May 1, 2015, through July 1, 2016.

36. Both Petitioner's Level I and Level II appeals were denied because DSGI maintains the termination was proper based on the language of the PPO Plan.

37. Petitioner initially sought relief through extension coverage until Husband would be covered by Medicare Part B.

38. Once the case was transferred to DOAH, Petitioner sought damages in the amount of health-related expenses incurred by Petitioner from the date of DSGI's termination of G.M.'s primary coverage.

39. At the final hearing, Jessica Bonin ("Bonin"), a 12-year employee of Florida Blue who handles appeals and processes PPO Plan payments, explained the provisions of the PPO Plan coordination of benefits. She testified that the PPO Plan pays benefits based on the allowed amount, which represents the

rate negotiated between Florida Blue and a network provider. When calculating amounts that are covered under the terms of the PPO Plan, the deductible, coinsurance, and amount allowed for each claim have to be applied. Therefore, not all charges billed by a provider will count toward the deductible or coinsurance maximum or be reimbursed after the deductible or coinsurance maximum is reached when calculating medical expenses.

40. Bonin calculated G.M.'s medical expenses in Respondent's Exhibit 18 and concluded that DSGI owed Petitioner $80.04 for a claim incurred on or about June 11, 2015. The reimbursement amount of $80.04 represents the amount the PPO Plan covers as secondary payer.

41. At hearing, DSGI also stipulated to another reimbursement in the amount of $18.03.

42. Husband testified he was seeking reimbursement for the entire amount of the combined statements regardless of whether charges were covered by Medicare or the PPO Plan's payment schedule. He totaled the statements from the health care providers at $47,056.56. G.M. also testified he did not know what monies were due on what bills.

43. G.M. specifically requested the $30,401.03 for the inpatient hospitalization at Aventura in December 2015. He

clarified that the bill that he received from Aventura was $3,455.72.

44. Medicare Part A, in which G.M. was enrolled at all times relevant to this matter, covers inpatient hospital expenses.

45. To date, G.M. has paid $4,415.19 out-of-pocket for medical expenses.

46. Petitioner failed to provide competent evidence to demonstrate a reimbursable amount for G.M.'s medical expenses.

CONCLUSIONS OF LAW

47. The Division of Administrative Hearings has jurisdiction over the parties to and the subject matter of this proceeding pursuant to sections 120.569 and 120.57(1), Florida Statutes (2016).[1/]

48. Respondent is the agency charged by the legislature with the duty to oversee the administration of the State Group Insurance Program pursuant to section 110.123, Florida Statutes.

49. The general rule is that the burden of proof, apart from a statutory directive, is on the party asserting the affirmative of an issue before an administrative tribunal. Young v. Dep't of Cmty. Aff., 625 So. 2d 831, 833-834 (Fla. 1993); Dep't of Transp. v. J.W.C. Co., 396 So. 2d 778, 788 (Fla. 1st DCA 1981); Balino v. Dep't of HRS, 348 So. 2d 349, 350 (Fla. 1st DCA 1977). Petitioner, as the party asserting the right to

a reimbursement for out-of-pocket medical expenses has the initial burden of demonstrating by a preponderance of the evidence her claim. If Petitioner meets this requirement, the burden shifts to Respondent to prove that the claim was not covered due to the application of policy exclusion. Herrera v. C.A. Seguros Catatumbo, 844 So. 2d 664, 668 (Fla. 3d DCA 2003); State Comprehensive Health Ass'n v. Carmichael, 706 So. 2d 319, 320 (Fla. 4th DCA 1997).

50. Petitioner seeks damages in the amount of health-related expenses incurred by Husband from the date of DSGI's termination of G.M.'s primary coverage for the period of May 1, 2015, until July 1, 2016. Petitioner asserts the application of estoppel applies in this matter. Petitioner maintains that Respondent is estopped from reliance on the PPO Plan language to the extent it removes Respondent from being primary payer. To prevail under estoppel, the party must prove the following: (1) the state agency represented a material fact contrary to its later asserted position; (2) the opposing party relied on the agency's earlier representation; and (3) the opposing party changed its position to its detriment, based on the state agency's representation. Hoffman v. Dep't of Mgmt. Servs., Div. of Ret., 964 So. 2d 163, (Fla. 1st DCA 2007); Black Bus. Inv. Fund of Cent. Fla., Inc. v. State, 178 So. 3d 931, 934 (Fla. 1st DCA 2015).

51. The undersigned is not persuaded by Nova Cas. Co. v. Waserstein, 424 F. Supp. 2d 1325 (S.D. Fla. 2006), to support Petitioner's contention that estoppel can be used to prevent forfeiture of insurance coverage. The instant matter is distinguishable because it is against a state agency, not private insurer, which has a different threshold standard for estoppel. Albright v. Union Bankers Ins. Co. 105 F. Supp. 2d 1330 (S.D. Fla. 2000), also fails to be compelling precedent in this matter as it addresses estoppel for ERISA, not the standard for a state agency.

52. As such, the standard for equitable estoppel only applies against a governmental entity in exceptional circumstances and must include some positive act or affirmative conduct on the part of a state officer that caused a serious injustice and upon which Petitioner had a right to rely and did rely to her detriment. See Wise v. Dep't of Mgmt. Servs., Div. of Ret., 930 So. 2d 867, 873 (Fla. 2d DCA 2006); Council Bros. v. City of Tallahassee, 634 So. 2d 264 (Fla. 1st DCA 1994).

53. The credible evidence as a whole does support a finding that Petitioner retired in 2012, thereby triggering the PPO Plan language allowing DSGI to pay secondary on medical claims. Despite the PPO Plan language, Respondent failed to act. It is uncontested that for over two years, Petitioner paid full premiums and received full coverage under the plan. The

representations of DSGI by accepting full payment and offering full coverage were contrary to the later-asserted position that Respondent intended to rely on the provisions of the PPO Plan and serve as a secondary payer. Furthermore, the McVays showed they relied on the representation. Petitioner testified they would have obtained alternative coverage, but they presumed they were covered by the PPO Plan since they were calling and renewing it annually. The reliance also caused G.M. to be without primary coverage for 14 months to his detriment.

54. It is important to note, Petitioner admitted at hearing that she received the PPO plans that were mailed to her although she did not review the part about Medicare Part B and eligibility. Hence, she was on constructive notice of the provisions regarding coordinated benefits and page 13-2. Additionally, DSGI admitted that the Husband's status was an administrative error that slipped through the system and was not caught. Even so, the record is void of any evidence proving either a positive act or affirmative conduct on the part of DSGI, which caused Petitioner to rely to her detriment. Accordingly, the agency standard for equitable estoppel has not been established in this case and any further inquiry for the remaining elements of estoppel is not required.

55. Even if Petitioner were able to meet her burden in establishing the elements of estoppel against DSGI, Petitioner

failed to prove Respondent should be the primary payer from May 1, 2015, through July 1, 2016, or that Petitioner is entitled to reimbursement for out-of-pocket medical expenses. G.M. was vague and vacillating when he was questioned regarding the medical expenses and statements. The record lacks competent substantial evidence of an amount Respondent would be required to cover or the actual amount Petitioner is responsible for out-of-pocket expenses. The undersigned is not persuaded by Petitioner's Exhibit 12, which specifically confirms "This is not a bill" on each statement. No credible competent evidence demonstrated that there was a reimbursable amount due for medical expenses. Therefore, the burden was not met regarding how much, if any, Respondent should cover. The evidence only establishes a conclusion that Respondent owes Petitioner $98.07, to which the parties stipulated.

RECOMMENDATION

Based on the foregoing Findings of Fact and Conclusions of Law, it is

RECOMMENDED that the Department of Management Services, Division of State Group Insurance, enter a final order denying the Petition and finding that Petitioner is entitled to reimbursement for Husband's medical expenses in the amount of $98.07.

DONE AND ENTERED this 31st day of January, 2017, in Tallahassee, Leon County, Florida.

JUNE C. MCKINNEY
Administrative Law Judge
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Filed with the Clerk of the
Division of Administrative Hearings
this 31st day of January, 2017.

ENDNOTE

1/ All references are to Florida Statutes 2016 unless otherwise stated.

COPIES FURNISHED:

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NOTICE OF RIGHT TO SUBMIT EXCEPTIONS

All parties have the right to submit written exceptions within 15 days from the date of this Recommended Order. Any exceptions to this Recommended Order should be filed with the agency that will issue the Final Order in this case.