SUPERIOR COURT OF NEW JERSEY
APPELLATE DIVISION
DOCKET NO. A-1012-21

BEVERLY DAIRSOW,

Petitioner-Appellant,

v.

STATE HEALTH BENEFITS COMMISSION,

Respondent-Respondent.

Submitted January 23, 2023 – Decided January 30, 2023

Before Judges Haas and Mitterhoff.

On appeal from the State Health Benefits Commission, Department of the Treasury.

Richard M. Pescatore, PC, attorneys for appellant (Jennifer M. Carlson, on the briefs).

Matthew J. Platkin, Attorney General, attorney for respondent (Sookie Bae-Park, Assistant Attorney General, of counsel; Jeffrey D. Padgett, Deputy Attorney General, on the brief).

PER CURIAM

Appellant Beverly Dairsow appeals from the October 18, 2021 final decision of the State Health Benefits Commission (Commission), which denied her request to retroactively enroll in the State Health Benefit Plan (the SHBP) retiree group more than three years after she retired. We affirm.

By way of background, the SHBP provides health coverage to qualified active employees and retirees of the State and participating local employers. See N.J.S.A. 52:14-17.25 to -17.45. An active employee may voluntarily terminate their SHBP coverage at any time. N.J.A.C. 17:9-7.4.

If an employee takes a leave of absence, as permitted by the federal Family Leave Act, 29 U.S.C. § 2601-2654, the employee may continue their coverage if they continue to pay their premium contributions. N.J.A.C. 17:9-7.3(a)(2) and (3)(ii). When an employee begins such a leave and wishes to retain their benefits, the "employer must make arrangements with the employee to receive direct payment for the required employee contribution." N.J.A.C. 17:9-7.3(a)(3)(iii). If the employee does not remit their required employee contribution, then their SHBP coverage will "terminate on the last day of the second coverage period following the last payroll period or month for which the employee received a salary payment if the total charge for the coverage is not paid by the employee[.]" N.J.A.C. 17:9-7.2(c)(4).

SHBP coverage generally "cease[s] upon the discontinuance of the term of office or employment or upon cessation of active full-time employment." N.J.S.A. 52:14-17.32(a). However, retiree SHBP coverage is available for "[r]etired employees of the State of New Jersey . . . , who were eligible for coverage as active employees immediately prior to retirement, and who continued coverage at retirement." N.J.A.C. 17:9-6.1(b)(1) (emphasis added).[1] In order to continue their coverage, the retiree must submit an application and pay the appropriate premium. N.J.A.C. 17:9-6.2(a)(2) and (b). "Should coverage lapse through no fault of the retired employee, the retired employee's spouse or eligible partner who would be eligible to continue such coverage, retroactive coverage for no more than six months may be granted, provided that the retroactive and currently due premiums are received." N.J.A.C. 17:9-6.2(a)(3). Employees who do not continue their SHBP coverage at the time of their retirement "will not be permitted to enroll in the SHBP at a later date." N.J.A.C. 17:9-6.2(b).

[1] In addition, the SHBP NJ DIRECT Member Guidebook, that was in effect when appellant retired in 2013, advised employees that "if you allow your active coverage to lapse (i.e., because of a leave of absence, reduction of hours, or termination of employment) prior to your retirement . . . you will lose your eligibility for Retired Group health coverage."

Turning to the facts of this case, appellant worked as an audiologist for the Vineland Developmental Center.[2] As a result, appellant had SHBP coverage. Appellant suffered "mini-strokes" in 2010 and again in August 2012. According to records obtained from the Division of Pensions (Division) and introduced by the Commission without objection at the administrative hearing in the Office of Administrative Law (OAL), appellant took an unpaid leave of absence from her employment beginning on December 24, 2012. One month later, on January 26, 2013, appellant's SHBP coverage terminated.[3] Appellant did not provide the Commission with any of her employment records at the hearing. However, she does not dispute that she did not pay premiums for any SHBP coverage during or after her leave of absence.

On September 15, 2013, appellant submitted an online application to the Division for an early retirement. She did not seek to reactivate her terminated SHBP coverage. On October 16, 2013, the Board of Trustees of the Public Employees' Retirement System (Board) approved appellant's early retirement application with an effective date of October 1, 2013. Because appellant did not

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[2] The Center is operated by the State Department of Human Services.

[3] At a subsequent Commission meeting, appellant's then-attorney advised the Commission that appellant was covered by her spouse's health insurance.

have SHBP coverage at the time of her retirement, she was not eligible for retiree coverage.

Over three years later, however, appellant submitted a "Medicare Enrollees Retired Coverage Enrollment Application"[4] to the Commission. Following a meeting, the Commission denied appellant's application on October 11, 2017. The Commission found that appellant was not eligible for SHBP retiree coverage because her active employee coverage terminated effective January 26, 2013 and, therefore, she did not carry that coverage into her retirement.

Appellant asked for an administrative hearing, and the Commission transmitted the case to the OAL. The Administrative Law Judge (ALJ) thereafter conducted a one-day hearing. As noted above, appellant did not provide any of her employment records concerning her leave of absence or the termination of her SHBP coverage on January 26, 2013. Instead, appellant briefly testified that she had suffered with memory issues since August 2012 and could no longer recall the circumstances of her unpaid leave or the termination of her SHBP coverage. Nevertheless, she stated she would not have

[4] The application was dated November 4, 2016.

intentionally let her benefits lapse.[5] Appellant also presented the testimony of her primary care physician, who opined that appellant suffered from "cognitive deficits" and would not have been attentive to paperwork, forms, and questionnaires.

The ALJ thereafter rendered a written initial decision and recommended that the Commission reinstate appellant's coverage. According to the ALJ, the Commission failed to "demonstrate that there was a lapse of health coverage. Nothing existed in the record to demonstrate that [appellant] was ever advised that her health benefits were terminated or that there was a proper basis for taking such adverse action."

On October 18, 2021, the Commission rejected the ALJ's recommendation and denied appellant's application to enroll in the SHBP retiree group as a "new retiree." In its detailed written decision, the Commission found that appellant's active employee coverage terminated in August 2013. Thereafter, she never paid any premiums for coverage and none of her health expenses were covered by the SHBP. Under these circumstances, appellant obviously knew she was no longer part of the SHBP. Appellant never attempted to reactive her coverage

[5] Appellant did not call her spouse as a witness to explain how appellant came to be covered by his health insurance policy.

prior to retirement. Accordingly, the Commission concluded that appellant was not eligible for retiree coverage under the clear terms of the governing statutes and regulations. This appeal followed.

On appeal, appellant argues that "the Commission's final administrative determination was arbitrary, capricious, and unreasonable; was not supported by substantial credible evidence in the record; and the Commission unreasonably rejected the ALJ's well[-]supported determination." For the reasons that follow, we are satisfied that appellant's contentions lack merit. We affirm substantially for the reasons the Commission set forth in its final decision, and add the following comments.

Our review of an agency's decision is limited. In re Stallworth, 208 N.J. 182, 194 (2011). "In order to reverse an agency's judgment, [we] must find the agency's decision to be 'arbitrary, capricious, or unreasonable, or [ ] not supported by substantial credible evidence in the record as a whole.'" Ibid. (second alteration in original) (quoting Henry v. Rahway State Prison, 81 N.J. 571, 579-80 (1980)). In determining whether agency action is arbitrary, capricious, or unreasonable, our role is restricted to three inquiries:

> (1) whether the agency action violates the enabling act's express or implied legislative policies; (2) whether there is substantial evidence in the record to support the findings upon which the agency based application of

> legislative policies; and (3) whether, in applying the legislative policies to the facts, the agency clearly erred by reaching a conclusion that could not reasonably have been made upon a showing of the relevant factors.
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> [W.T. v. Div. Med. Assistance & Health Servs., 391 N.J. Super. 25, 35-36 (App. Div. 2007) (quoting Pub. Serv. Elec. & Gas Co. v. N.J. Dep't of Envtl. Prot., 101 N.J. 95, 103 (1985)).]

Thus, the burden of showing the agency acted in an arbitrary, capricious, or unreasonable manner rests on the party opposing the administrative action. E.S. v. Div. of Med. Assistance & Health Servs., 412 N.J. Super. 340, 349 (App. Div. 2010) (citing In re Arenas, 385 N.J. Super. 440, 443-44 (App. Div. 2006)). It is not the function of the reviewing court to substitute its independent judgment on the facts for that of an administrative agency. In re Grossman, 127 N.J. Super. 13, 23 (App. Div. 1974).

We must also "'defer to an agency's technical expertise, its superior knowledge of its subject matter area, and its fact-finding role,'" and therefore are "obliged to accept all factual findings that are supported by sufficient credible evidence." Futterman v. Bd. of Review, Dep't of Labor, 421 N.J. Super. 281, 287 (App. Div. 2011) (quoting Messick v. Bd. of Rev., 420 N.J. Super. 321, 325 (App. Div. 2011)). Although we are not bound by an agency's interpretation of law, we accord a degree of deference when the agency interprets a statute or

a regulation that falls "within its implementing and enforcing responsibility . . . ." Wnuck v. N.J. Div. of Motor Vehicles, 337 N.J. Super. 52, 56 (App. Div. 2001) (citation omitted). Our authority to intervene is limited to "those rare circumstances in which an agency action is clearly inconsistent with [the agency's] statutory mission or with other State policy." Futterman, 421 N.J. Super. at 287 (alteration in original) (internal quotation marks omitted).

Furthermore, "[i]t is settled that '[a]n administrative agency's interpretation of statutes and regulations within its implementing and enforcing responsibility is ordinarily entitled to our deference.'" E.S., 412 N.J. Super. at 355 (second alteration in original) (quoting Wnuck, 337 N.J. Super. at 56). "Nevertheless, 'we are not bound by the agency's legal opinions.'" A.B. v. Div. of Med. Assistance & Health Servs., 407 N.J. Super. 330, 340 (App. Div. 2009) (quoting Levine v. State Dep't of Transp., 338 N.J. Super. 28, 32 (App. Div. 2001)). "Statutory and regulatory construction is a purely legal issue subject to [our] de novo review." Ibid.

Applying these principles, we discern no basis for disturbing the Commission's well-reasoned determination that appellant was not eligible for retiree coverage. The statutes and regulations are clear. In order to obtain retiree coverage, the employee must carry their active coverage into their

retirement. Appellant failed to do so. Her coverage terminated almost nine months before she retired. She did not attempt to reinstate her coverage for over three years. Thus, she was no longer eligible for enrollment. See N.J.A.C. 17:9-6.2(b).

Appellant continues to argue that she was unaware that her benefits ended in January 2013. In addition to her own testimony, she points to her physician's assertion that appellant would not have been able to pay attention to any forms or records during this period. However, the record supports the Commission's determination that appellant had to have been aware of the status of her coverage because she continued to receive medical services even though the SHBP did not pay any of appellant's ongoing medical bills following the termination of her benefits.[6]

The Commission also properly rejected the ALJ's determination that "the State" failed to make arrangements for appellant to continue her benefits after she began her unpaid leave of absence. Appellant had the burden of proof in this matter and she failed to present any of her employment records concerning

[6] As noted above, appellant was covered by her husband's health insurance plan. The Commission stated in its decision that appellant's former attorney stated appellant "wanted SHBP coverage instead because of 'issues with her husband's insurance.'"

her leave request or its processing by the Vineland Developmental Center. Thus, the ALJ's determination lacked an evidentiary basis in the record.

In sum, appellant did not qualify for SHBP benefits at the time of her retirement. Therefore, the Commission properly denied her application to reinstate these benefits three years after she retired.

Affirmed.

I hereby certify that the foregoing is a true copy of the original on file in my office.

CLERK OF THE APPELLATE DIVISION