



Rhode Island Executive Office of Health and Human Services
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Docket # 14-2011
Hearing Date: March 16, 2015

Date: April 3, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Telephonic Hearing that you requested has been decided for you. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

**EXECUTICE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
HEALTHSOURCE RI POLICY MANUAL
SECTION: 4 ADVANCED PREMIUM TAX CREDITS and COST SHARING REDUCTION**

The facts of your case, the Agency regulation(s) and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the Appellant) and Noah Zimmerman, Esq., Lindsay Lang, Esq. and David Dee, Esq. the Agency Representatives from HealthSource RI.

Present for the telephonic hearing were: You (the Appellant) and Noah Zimmerman, Esq., the Agency Representative from HealthSource RI.

ISSUE: Should the Appellant's spouse been allowed to enroll for a HSRI healthcare policy that received tax credits if she is a Medicare recipient?

EOHHS RULES AND REGULATIONS:

Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

APPEAL RIGHTS:

Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR) and HealthSource RI Policy Manual.

DISCUSSION OF THE EVIDENCE:

The HealthSource RI Representatives testified:

- HSRI is not contesting that mistakes were made on their part when the Appellant signed up for coverage. Apparently, the Appellant informed the customer service HSRI representative when signing up for healthcare that his wife is on Medicare but the representative marked down that the spouse was not receiving Medicare. Due to the Appellant's spouse receiving Medicare, she is not eligible for healthcare with tax credits through HSRI.
- HSRI issued a notice to the Appellant dated April 12, 2014 seeking additional documentation. The notice stated that HSRI had external data sources which indicated that the Appellant/spouse had access to Medicare and that if this notice isn't addressed, it may put the healthcare coverage at risk.
- Although HSRI acknowledges their error in signing the Appellant's spouse up for coverage, had the Appellant responded to the April 12, 2014 notice, the expenses would not have been as large as they are.

The Appellant testified:

- Appellant filed an Appeal on October 7, 2015 because when he signed up for Obamacare, he told the representative that his wife was on SSDI/Medicare and had been for years but the representative signed up both the Appellant and his SSDI/Medicare recipient wife for Obamacare.
- On January 15, 2014 HSRI issued a notice to the Appellant, informing him that both he and his wife have been signed up to receive a qualified health plan (QHP) with tax credits.
- The Appellant was paying \$76.54 per month as a healthcare insurance premium monthly for both himself and spouse while also receiving tax credits.
- The Appellant denies ever receiving a HSRI notice dated April 12, 2014.
- The Appellant filed his Appeal due to someone other than himself made mistakes and that he should not be held responsible for those mistakes.

FINDINGS OF FACT:

- The Appellant had worked with a customer services representative from HSRI to obtain healthcare. During the application process the Appellant's spouse was also granted eligibility for an insurance healthcare policy with tax credit, this was done in error since the Appellant's spouse is Medicare eligible and has been receiving SSDI for years.
- On January 15, 2014 HSRI issued a notice to the Appellant, informing him that both he and his wife have been signed up to receive a qualified health plan (QHP) with tax credits.

- The Appellant and his spouse were allowed to sign up for a healthcare policy, receiving tax credits, in the amount of \$76.54 as a monthly premium.
- There is some question as to whether the Appellant received an April 12, 2014 notice from HSRI was requesting additional documentation; HSRI had received information that the Appellant's spouse had access to Medicare and if the information isn't provided to HSRI, the Appellant and/or his spouse's coverage would be at risk.
- The Appellant testified that neither he nor his spouse received the April 12, 2014 notice from HSRI and therefore never able to replied to it.
- HSRI is not contesting that mistakes were made on their part when the Appellant signed up. Apparently, the Appellant informed the customer service HSRI representative when signing up for healthcare that his wife is on Medicare but the representative marked down that the spouse was not receiving Medicare. Due to the Appellant's spouse receiving Medicare, she is not eligible for healthcare with tax credits through HSRI.
- Although HSRI acknowledges their error in signing the Appellant's spouse up for coverage, had the Appellant responded to the April 12, 2014 notice, the expenses would not have been as large as they are.

CONCLUSION:

The issue to be decided is whether the Appellant's spouse should have been allowed to enroll for a HSRI healthcare policy that received tax credits if she is a Medicare recipient?

The Appellant applied for "Obamacare" through HSRI because HSRI "helps people get healthcare coverage". The Appellant provided all the information and documents that he had been requested to provide from the customer services representative from HSRI. With the assistance of a customer service representative from HSRI, the Appellant was able to obtain healthcare cover for \$76.54 per month as a premium and receiving tax credits. On January 15, 2014, HSRI issued a QHP Enrollment Notice, which informed the Appellant of his monthly premium amount and the amount of the tax credit that he and his spouse would be receiving to off- set the cost of the healthcare premium.

Unfortunately, HSRI didn't know or failed to ask if either the Appellant or his spouse had other healthcare coverage and in particular, did either one have Medicare; this is a standard question in the application. The Appellant gave testimony that he told the customer services representative while completing the HSRI application that his spouse receives Medicare, she if very sick and has been on SSI for many years.

HealthSource RI Policy Manual states in Chapter 4:

- 4) Ineligibility Based on Access to Minimum Essential Coverage

a) Government-Sponsored MEC

An individual is considered eligible for government-sponsored MEC (**and therefore ineligible for an APTC**) if he/she meets the eligibility criteria for coverage under the programs listed below. Unless otherwise noted, it is eligibility for the program – not actual enrollment in it – that makes someone ineligible for an APTC.

Government programs:

- Enrolled in Medicare Part A requiring payment of premiums (most Medicare beneficiaries do not need to pay Part A premiums and are automatically considered eligible for MEC)
- Medicare Advantage plans (Medicare Part C)
- Medicaid, **other than** for:
 - Optional coverage of family planning services
 - Optional coverage of tuberculosis-related services
 - Coverage of pregnancy-related services
 - Coverage of emergency medical services
- CHIP
 - Note that children age one and above who lose CHIP coverage due to a failure to pay premiums and who may not re-enroll in CHIP for four months are treated as eligible for CHIP and do not qualify for an APTC during that time period.
- Enrolled in TRICARE
- Enrolled in veterans' health coverage
- Peace Corps and AmeriCorps volunteer programs
- Refugee medical assistance supported by the Administration for Children and Families
- Enrolled in a student health plan
- Enrolled in State high risk pool coverage

In this case, it has been indicated that the Appellant's spouse receives Medicare and has been for a number of years, which is a contradiction of HSRI's own policy by allowing her eligibility. Since the Appellant's spouse is a Medicare recipient, she is ineligible to receive a healthcare policy with Advanced Premium Tax Credits (APTC), which is exactly what she had been allowed to sign up for. People are ineligible for an APTC if they can secure adequate coverage (i.e., "minimum essential coverage" (or MEC) through a source other than the Health Benefits Exchange. (45 CFR 155.305(f)) The Appellant's spouse is deemed as having MEC since she has Medicare.

The Appellant testified under oath that he informed the customer service representative from HSRI that his spouse was active on Medicare when he was applying for healthcare and the HSRI representative present at this Appeals Hearing did not contest any of the Appellant's statements. The Appellant voiced his concern that why would HSRI wait four months to correct an error that happened during the application phase and then place the burden on the Appellant to produce his spouses Medicare records. The Appellant's concern is regarding the April 12, 2014 notice where HSRI was seeking additional documentation and that he did not receive.

In summary, the Appellant and his spouse completed an application with the assistance of a customer service representative from HSRI for healthcare in January 2014. The Appellant presented uncontested testimony that he informed the customer services representative that his spouse was receiving Medicare and had been for years due to an illness. During this application process, the customer services representative enrolled both the Appellant and his spouse in a healthcare policy that had tax credits. Due to the Appellant spouse receiving Medicare, she is ineligible for a healthcare policy that also offers tax credits and is against state policy and the Code of Federal Regulations.

Since the Appellant's spouse has Medicare, she already has a minimum essential coverage (MEC). HSRI Policy Manual states that:

An individual is considered eligible for government-sponsored MEC (**and therefore ineligible for an APTC**) if he/she meets the eligibility criteria for coverage under the programs listed below. Unless otherwise noted, it is eligibility for the program – not actual enrollment in it – that makes someone ineligible for an APTC.

HSRI Policy Manual also lists some of the Government-Sponsored MEC in Chapter 4:

- Enrolled in Medicare Part A requiring payment of premiums (most Medicare beneficiaries do not need to pay Part A premiums and are automatically considered eligible for MEC)
- Medicare Advantage plans (Medicare Part C)
- Medicaid, **other than** for:
 - Optional coverage of family planning services
 - Optional coverage of tuberculosis-related services
 - Coverage of pregnancy-related services
 - Coverage of emergency medical services
- CHIP
 - Note that children age one and above who lose CHIP coverage due to a failure to pay premiums and who may not re-enroll in CHIP for four months are treated as eligible for CHIP and do not qualify for an APTC during that time period.

- Enrolled in TRICARE
- Enrolled in veterans' health coverage
- Peace Corps and AmeriCorps volunteer programs
- Refugee medical assistance supported by the Administration for Children and Families
- Enrolled in a student health plan
- Enrolled in State high risk pool coverage

After a careful review of the Agency's policies, as well as the evidence and testimony given, this Appeals Officer finds that the Appellant's spouse should not have been allowed to enroll in a HSRI healthcare policy that offered tax credits since she already has minimum essential coverage with Medicare. The Appellant's request for relief is therefore granted.

ACTION TO BE TAKEN BY HEALTHSOURCE RI

HSRI IS TO REMOVE THE APPELLANT'S SPOUSE FROM THE APPLICACION THAT HAD BEEN SUBMITTED IN JANUARY 2014 AND TO REPROCESS THE APPLICATION FOR JUST THE APPELLANT.



Appeals Officer

APPENDIX

**EXECUTICE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
HEALTHSOURCE RI POLICY MANUAL**

4) Ineligibility Based on Access to Minimum Essential Coverage

In general, people are ineligible for an APTC if they can secure adequate coverage (i.e., “minimum essential coverage” (or MEC) through a source other than the Health Benefits Exchange.¹ This requirement is meant to limit the availability of the APTC only to people who do not have alternative coverage options through their jobs, government programs, or other sources.

a) Definition of MEC for Purposes of APTC Eligibility²

For purposes of APTC eligibility, the term “minimum essential coverage” means coverage under any of the following:

- Most government-sponsored insurance (see discussion below);
- Eligible employer-sponsored insurance (see discussion below);
- Grandfathered health plans;³ and
- Other coverage that is recognized as MEC by the Secretary of Health and Human Services, including foreign health coverage and self-funded student health coverage.

Note, however, that some types of very limited coverage are not considered “MEC”.

These “excepted benefits” policies include the following:⁴

- Accidental death and dismemberment coverage
- Disability insurance
- General liability insurance
- Automobile liability insurance
- Workers’ compensation
- Credit-only insurance (e.g. mortgage insurance)
- Coverage for employer-provided on-site medical clinics

¹ 45 CFR 155.305(f), 26 CFR 1.36B-2(c)

² 26 USC 5000A(f); Proposed 26 CFR 1.5000A-2; Proposed 45 CFR 156.602. Note that the concept of MEC also is used to determine who may be exempt from a shared responsibility payment. For this purpose, the list of coverage that constitutes MEC is slightly different as discussed in Chapter X.

³ A grandfathered health plan is a group health plan or group health insurance coverage that was already in existence on March 23, 2010, when the Affordable Care Act was signed into law. Grandfathered status excludes plans from certain mandates under the law (ACA Section 1251; Proposed 26 CFR 1.5000A-2(e)).

⁴ 26 USC 5000A(f)(3)

- Limited-scope dental or vision benefits
- Long-term care benefits
- Benefits provided under most health flexible spending arrangements
- Policies that cover only a specified disease or illness (e.g. cancer-only policies)
- Supplemental coverage, such as Medicare supplemental policies, TRICARE supplemental policies, and similar supplemental coverage to coverage under a group health plan.

b) Government-Sponsored MEC

An individual is considered eligible for government-sponsored MEC (and therefore ineligible for an APTC) if he/she meets the eligibility criteria for coverage under the programs listed below.⁵ Unless otherwise noted, it is eligibility for the program – not actual enrollment in it – that makes someone ineligible for an APTC.

Government programs:⁶

- Enrolled in Medicare Part A requiring payment of premiums⁷ (most Medicare beneficiaries do not need to pay Part A premiums and are automatically considered eligible for MEC)
- Medicare Advantage plans (Medicare Part C)
- Medicaid, **other than** for:
 - Optional coverage of family planning services
 - Optional coverage of tuberculosis-related services
 - Coverage of pregnancy-related services
 - Coverage of emergency medical services
- CHIP
 - Note that children age one and above who lose CHIP coverage due to a failure to pay premiums and who may not re-enroll in CHIP for four months are treated as eligible for CHIP and do not qualify for an APTC during that time period.
- Enrolled in TRICARE
- Enrolled in veterans' health coverage⁸

⁵ 26 CFR 1.36B-2(c)(2)(i)

⁶ 26 CFR 5000A(f)(1); 26 CFR 1.36B-2(c)(2)(i); Proposed 26 CFR 1.5000A-2(b); Proposed 45 CFR 156.602

⁷ Proposed IRS Notice 2013-41, issued on June 26, 2013. Available at: [http://op.bna.com/dt.nsf/id/sdoe-992kz2/\\$File/Notice%202013-41.pdf](http://op.bna.com/dt.nsf/id/sdoe-992kz2/$File/Notice%202013-41.pdf).

- Peace Corps and AmeriCorps volunteer programs
- Refugee medical assistance supported by the Administration for Children and Families
- Enrolled in a student health plan⁹
- Enrolled in State high risk pool coverage¹⁰

Code of Federal Regulations

45 CFR 155.305(f)

(f) Eligibility for advance payments of the premium tax credit—(1) In general. The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that—

(i) He or she is expected to have a household income, as defined in 26 CFR 1.36B-1(e), of greater than or equal to 100 percent but not more than 400 percent of the FPL for the benefit year for which coverage is requested; and

(ii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse—

(A) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in paragraph (a) of this section; and

(B) Is not eligible for minimum essential coverage, with the exception of coverage in the individual market, in accordance with section 26 CFR 1.36B-2(a)(2) and (c).

⁸ The veterans' health coverage programs that represent MEC for those who are enrolled include the medical benefits package authorized for eligible veterans under 38 U.S.C. 1710 and 38 U.S.C. 1705; the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA) authorized under 38 U.S.C. 1781; comprehensive health care program authorized under 38 U.S.C. 1803 and 38 U.S.C. 1821 for certain children of Vietnam Veterans and Veterans of covered service in Korea who are suffering from spina bifida; and the Nonappropriated Fund Health Benefits Program of the Department of Defense (*Proposed 26 U.S.C. 1.5000A-2(b)(5) and (7)*).

⁹ Proposed IRS Notice 2013-41, issued on June 26, 2013. Available at: <http://www.irs.gov/pub/irs-drop/n-13-41.pdf>

¹⁰ The proposed rule designates state high risk pools as MEC subject to further review by the Secretary (*Proposed 45 CFR 156.602(e)*). HHS specifically notes that it "reserves the right to review and monitor the extent and quality of coverage, and in the future to reassess whether they should be designated minimum essential coverage or should be required to go through the same [designation] process outlined in 156.604" of the proposed rule (*Preamble 7361*). The proposed IRS notice 2013-41 issued on June 26, 2013 states that individuals are eligible for MEC for purposes of APTC eligibility if they are enrolled in high risk pool coverage. Available at: <http://www.irs.gov/pub/irs-drop/n-13-41.pdf>

(2) Special rule for non-citizens who are lawfully present and who are ineligible for Medicaid by reason of immigration status. The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that—

(i) He or she meets the requirements specified in paragraph (f)(1) of this section, except for paragraph (f)(1)(i);

(ii) He or she is expected to have a household income, as defined in 26 CFR 1.36B-1(e) of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(iii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status, in accordance with 26 CFR 1.36B-2(b)(5).

(3) Enrollment required. The Exchange may provide advance payments of the premium tax credit on behalf of a tax filer only if one or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the tax filer and his or her spouse, is enrolled in a QHP that is not a catastrophic plan, through the Exchange.

(4) Compliance with filing requirement. The Exchange may not determine a tax filer eligible for advance payments of the premium tax credit if HHS notifies the Exchange as part of the process described in §155.320(c)(3) that advance payments of the premium tax credit were made on behalf of the tax filer or either spouse if the tax filer is a married couple for a year for which tax data would be utilized for verification of household income and family size in accordance with §155.320(c)(1)(i), and the tax filer or his or her spouse did not comply with the requirement to file an income tax return for that year as required by 26 U.S.C. 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit for that period.

(5) Calculation of advance payments of the premium tax credit. The Exchange must calculate advance payments of the premium tax credit in accordance with 26 CFR 1.36B-3.

(6) Collection of Social Security numbers. The Exchange must require an application filer to provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

This hearing decision constitutes a final order pursuant to RI General Laws §42-35-12. An appellant may seek judicial review to the extent it is available by law. 45 CFR 155.520 grants appellants who disagree with the decision of a State Exchange appeals entity, the ability to appeal to the U.S. Department of Health And Human Services (HHS) appeals entity within thirty (30) days of the mailing date of this decision. The act of filing an appeal with HHS does not prevent or delay the enforcement of this final order.

You can file an appeal with HHS at <https://www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf> or by calling 1-800-318-2596.