Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
phone: 401.462.2132 fax: 401.462.0458

Date: July 3, 2015

Docket # 15-705
Hearing Date: May 11, 2015

[redacted]

ADMINISTRATIVE HEARING DECISION

The Administrative 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)
SECTION: 0302 MEDICAID APPLICATION

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., a Representative from Health Source RI.

Present at the hearing were: You (the Appellant) and Noah Zimmerman, Esq., a Representative from Health Source RI.

ISSUE: Had the Appellant ever received notice of the change is his policy's monthly premium.

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).

DISCUSSION OF THE EVIDENCE:

The HealthSource RI Representatives testified:

- It appears that the Appellant was being charged the 2014 rates instead of the 2015 rates.
- Records show that the Appellant's premium went up to $688.25 for April 2015 and this appears to be an error, a billing issue.
- The payment for May 2015 appears to be $688.25; the tax credit is $300.91.
- It appears that the new premium might be $388.
- The carriers set the premiums and not HSRI.
- There appears to be a problem on how the premium was calculated and that there is a billing error.

The Appellant testified:

- The Appellant feels that there has been a breach of contract and false representation of a subscriber.
- The Appellant testified that on December 18, 2014 he had re-enrolled in a health plan through HSRI for his spouse and was told that her monthly share for 2015 would be $146.27 each month.
- On February 26, 2015 the Appellant received a telephone call from HSRI and informed him that they had mistakenly used 2014 rates when HSRI re-enrolled the Appellant for 2015.
- The Appellant received two notices from HSRI, one on February 28, 2015 labeled "Eligibility Decision Notice" and the other on March 2, 2015 labeled "Enrollment Notice", both indicating that the Appellant's spouse BC/BS coverage will begin on March 1, 2015 and that the Appellant's monthly share is $326.93.
- The Appellant feels that it is improper for anyone other than himself to change the enrollment or disenrollment of a plan; someone other than himself dis-enrolled in a plan that he had picked and then enrolled his spouse in a different plan.

- The Appellant picked a plan in December of 2014 that would cost him $146.27 but by February 2015 someone had dis-enrolled his spouse from that plan and picked a different one that would cost him $326.93 per month.
- The Appellant submitted five different invoices from HSRI; invoice dates 12-30-14, 01-05-15, 02-23-15, 04-23-15 and 04-28-15. (labeled Appellant exhibit I)
- The HSRI invoice dated 12-30-14 show that a payment was received on 12-24-14 in the amount of $146.27 and the tax credit received was $456.05; the invoice dated 01-05-15 shows that nothing is past due and a payment was received 12-24-14 and a tax credit received was $456.05; the invoice dated 01-29-15 shows that nothing is past due, a payment of $146.27 was received on 01-21-15 and the tax credit of $456.05 was received; the invoice dated 04-23-15 shows that nothing is past due, a payment was received on March 9, 2015 in the amount of $292.54 and a tax credit of $602.32 was received but this invoice also indicated that $688.25 was due from the Appellant by 4-23-15; and the invoice dated 04-28-15 shows that nothing is past due, a payment was received 4-24-15 in the amount of $688.25 and again this invoice also indicated that $688.25 is due by 5-23-15.
- The Appellant also presented a printout from Rite Aid Pharmacy dated 4-11-215 that states that the Appellant's spouse's coverage is inactive, coverage terminated 3-31-2015.
- The Appellant states that he received a telephone call for HSRI and was told that he needs to pay $688.25 and nothing can be done about it. The Appellant told the customer service representative to put in writing and send him a bill.
- The Appellant states that there wasn't a plan in January 2015 and possibly February 2015; March 2015 the plan was in place; but on April 1, 2015 the plan was placed in "pend" status were it remains today and can't be used.
- The Appellant and his spouse are so frustrated with HSRI, that they are paining on cancelling their coverage and getting coverage though other ways.

FINDINGS OF FACT:

- It appears that the Appellant was being charged the 2014 rates instead of the 2015 rates.
- Records show that the Appellant's premium went up to $688.25 for April 2015 and this appears to be an error, a billing issue.
- The payment for May 2015 appears to be $688.25; the tax credit is $300.91.
- It appears that the new premium might be $388
- The carriers set the premiums and not HSRI.
- The Appellant testified that on December 18, 2014 he had re-enrolled in a health plan through HSRI for his spouse and was told that her monthly share for 2015 would be $146.27 each month.
- On February 26, 2015 the Appellant received a telephone call from HSRI and informed him that they had mistakenly used 2014 rates when HSRI re-enrolled the Appellant for 2015.

- The Appellant received two notices from HSRI, one on February 28, 2015 labeled "Eligibility Decision Notice" and the other on March 2, 2015 labeled "Enrollment Notice", both indicating that the Appellant's spouse BC/BS coverage will begin on March 1, 2015 and that the Appellant's monthly share is $326.93.
- The Appellant picked a plan in December of 2014 that would cost him $146.27 but by February 2015 someone had dis-enrolled his spouse from that plan and picked a different one that would cost him $326.93 per month.
- The Appellant submitted five different invoices from HSRI; invoice dates 12-30-14, 01-05-15, 02-23-15, 04-23-15 and 04-28-15. (labeled Appellant exhibit I)
- The HSRI invoice dated 12-30-14 show that a payment was received on 12-24-14 in the amount of $146.27 and the tax credit received was $456.05; the invoice dated 01-05-15 shows that nothing is past due and a payment was received 12-24-14 and a tax credit received was $456.05; the invoice dated 01-29-15 shows that nothing is past due, a payment of $146.27 was received on 01-21-15 and the tax credit of $456.05 was received; the invoice dated 04-23-15 shows that nothing is past due, a payment was received on March 9, 2015 in the amount of $292.54 and a tax credit of $602.32 was received but this invoice also indicated that $688.25 was due from the Appellant by 4-23-15; and the invoice dated 04-28-15 shows that nothing is past due, a payment was received 4-24-15 in the amount of $688.25 and again this invoice also indicated that $688.25 is due by 5-23-15.
- The Appellant also presented a printout from Rite Aid Pharmacy dated 4-11-215 that states that the Appellant's spouse's coverage is inactive, coverage terminated 3-31-2015.
- The Appellant states that there wasn't a plan in January 2015 and possibly February 2015; March 2015 the plan was in place; but on April 1, 2015 the plan was placed in "pend" status were it remains today and can't be used.

CONCLUSION:

The issue to be decided is whether the Appellant ever receive notice with regards to a change is his policy's monthly premium.

The Appellant reenrolled into a health plan for his spouse through HSRI on December 18, 2014 that was to begin on January 1, 2015. Having worked with a HSRI customer service representative, the plan that was picked would require the Appellant to pay his share of the policy, $146.27 monthly, plus receive $456.05 in tax credits. On December 24, 2014 HSRI received the Appellant's payment of $146.27 for January 2015.

On January 05, 2015, HSRI issued an invoice to the Appellant informing him that he has a zero balance and that $146.27 was due on January 23, 2015. On January 29, 2015, HSRI issued an invoice to the Appellant informing him that a payment of $146.27 was received on January 21, 2015, that $0.00 is past due and that $146.27 is due by February 23, 2015. On March 26, 2015 HSRI issued an invoice informing the Appellant

that on March 9, 2015 a payment of $292.54 was received, $0.00 is past due and that $688.25 is due by April 23, 2015. On April 28, 2015, HSRI issued an invoice that reflects that there is nothing past due from the Appellant; that a payment of $688.25 was made on April 24, 2015 in the amount of $ $688.25; and that $688.25 is due by May 23, 2015.

The Appellant testified, which the HSRI agreed, that the Appellant was given the wrong information regarding the premium pricing for 2015; HSRI provided the Appellant with 2014 premium prices instead of using 2015 premium prices. The HSRI representative present at Hearing also indicated that it is the insurance companies that set the premium rates, not HSRI.

HSRI issued an Eligibility Decision Notice to the Appellant on February 28, 2015 informing him that his spouse's BC/BS premium will be $326.93 effective March 1, 2015. HSRI also issued an Enrollment Notice on March 2, 2015 informing the Appellant that his spouse's BC/BS premium will be $326.93 effective March 1, 2015 but yet the Appellant received an invoice dated April 24, 2015 indicating that his premium share is $688.25. The Appellant never received a notice for this increase. The HSRI representative feels that there has been some billing issues and cannot understand the large increase in the Appellant's cost of the premium share.

In accordance with MCAR Policy § 0302 D – Period of Eligibility, written notice is to be provided by the agency to the applicant informing him/her of his or her eligibility, the basis for the decision and the applicant's rights to appeal and request a hearing. The notice is to indicate the length of time the applicant is eligible.

> § 0302 D Written notice is provided to each applicant stating the Medicaid agency's eligibility decision, the basis for the decision, and an applicant's right to appeal and request a hearing. In instances in which the applicant is determined to be eligible, a notice is provided indicating the length of time the applicant will remain eligible – the "*eligibility period*" -- until before a renewal of continuing eligibility is required. The period of Medicaid eligibility for IHCC group members is as follows:
>
> (1) General eligibility period. When an individual is determined eligible for Medicaid, eligibility exists for the entire first month. Therefore, eligibility begins on the first day of the month in which the individual is determined eligible. Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given or the beneficiary fails to renew eligibility as required. Medicaid benefits cease on the last day of the ten (10) day notice period when eligibility is determined to no longer exist. Individual and couple cases remain eligible for

> Medicaid for up to a maximum of twelve (12) months. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.

The Appellant in this matter never received any notice informing him that his spouse's healthcare premium share was increasing to $688.25. Furthermore, the Appellant provided testimony and submitted evidence from RiteAid Pharmacy that indicates as of March 31, 2015, the Appellant's spouse's healthcare coverage had been terminated, which was also done without any notice and is also in violation of policy.

In summary, the Appellant re-enrolled his spouse in a BC/BS healthcare plan through HSRI for 2015. With the assistance of a customer service representative from HSRI, the Appellant picked a plan and paid $146.27 as part of the Appellant's spouse's share of the premium and the balance would be paid with tax credits. This payment was received by HSRI on December 24, 2014, prior to the December 31, 2014 dead line and was to take effect on January 1, 2015. The Appellant received invoices in January, February and March 2015 that indicates that the Appellant's premium share is $146.27.

HSRI issued an Eligibility Decision Notice on February 28, 2015 informing the Appellant that his monthly bill will be $326.93 effective March 1, 2015 and again on March 2, 2015. HSRI admitted during hearing that they may have use 2014 rates instead of using 2015 rate when informing the Appellant how much his monthly premium share would be. But suddenly on April 28, 2015, the Appellant received an invoice informing him that his new monthly charge would be $688.25. Neither the Appellant nor his spouse ever received a notice informing them of this increase. During this hearing the representative from HSRI indicated that the Appellant's monthly premium share maybe $388.00, although a notice for this amount has not been issued.

On April 11, 2015 the Appellant was informed by RiteAid Pharmacy that his spouse's healthcare coverage was terminated on March 31, 2015; again, without notice. MCAR Policy 0302 specifically states, "Written notice is provided to each applicant stating the Medicaid agency's eligibility decision"; HSRI failed to provide proper written notice in this matter.

After a careful review of the Agency's policies, as well as the evidence and testimony given, this Appeals Officer finds that the Appellant was not provided proper notice. The appellant's request for relief is therefore granted.

CORRECTIVE ACTION TO BE TAKEN BY THE AGENCY:

HSRI is to calculate with BC/BS what the Appellant's spouse's monthly premium share and tax credits should be, correct the figure on HSRI's computer system and issue a notice to the Appellant. HSRI will determine when the Appellant's

spouse's healthcare coverage existed and rectify this issued with their billing department, this may create that the Appellant will receive a credit for when payments were made but coverage did not exist.

HSRI is to notify this Hearing Officer within 30-days of this decision that the Corrective Actions have been completed.

Thomas Isaacs

Appeals Officer

APPENDIX

EXECUTICE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

0302 Medicaid Application – Integrated Health Care Coverage Groups

D. **Period of Eligibility**
REV: June 2014
Written notice is provided to each applicant stating the Medicaid agency's eligibility decision, the basis for the decision, and an applicant's right to appeal and request a hearing. In instances in which the applicant is determined to be eligible, a notice is provided indicating the length of time the applicant will remain eligible – the "*eligibility period*" -- until before a renewal of continuing eligibility is required. The period of Medicaid eligibility for IHCC group members is as follows:

(1) General eligibility period. When an individual is determined eligible for Medicaid, eligibility exists for the entire first month. Therefore, eligibility begins on the first day of the month in which the individual is determined eligible. Medicaid ends when the individual is determined to no longer meet the program's eligibility requirements and proper notification has been given or the beneficiary fails to renew eligibility as required. Medicaid benefits cease on the last day of the ten (10) day notice period when eligibility is determined to no longer exist. Individual and couple cases remain eligible for Medicaid for up to a maximum of twelve (12) months. Certifications may be for LESSER periods if a significant change occurs or is expected to occur that may affect eligibility.

(2) Special eligibility period – Medically-needy. In cases where the *flexible test of income* policy is applied, eligibility is established on the day the excess income is absorbed (i.e., the day the health service was provided). Eligibility is for the balance of the six (6) month period. Medically-needy eligibility continues for the full six (6) months or the balance of the six (6) month period.

(3) Medicare Premium Payment Program. Individuals eligible for benefits as a Qualified Medicare Beneficiary (QMB), a Special Low Income Medicare Beneficiary (SLMB) or a Qualified Working Disabled Individual (QWDI) are certified for a 12-month period. A Qualifying Individual (QI-1 or QI-2) is certified to the end of the calendar year.

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.