



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

June 5, 2015

Docket # 15-214
Hearing Date: April 30, 2015



ADMINISTRATIVE HEARING DECISION

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

**EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION 1307 MAGI INCOME AND ELIGIBILITY STANDARDS
SECTION 1307.02 DEFINITIONS**

**RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH
BENEFITS EXCHANGE (RIHBE)
SECTION 4.0 Initial Open Enrollment, Annual Open Enrollment, and Special
Enrollment Periods
SECTION 4.4 Annual Open Enrollment Period
SECTION 4.5 Annual Open Enrollment Period Coverage Effective Dates.
SECTION 9.0 Agreements with Issuers**

The facts of your case, the Agency regulations, 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 Health Source RI (HSRI) Agency representatives: Noah Zimmerman, David Dee, and Lindsay Lang.

Present at the hearing were: You (the Appellant), your friend, and HSRI representative Noah Zimmerman.

ISSUE: Should the appellant's advanced premium tax credits (APTCs) have gone down if her income remained the same?

EOHHS RULES AND REGULATIONS:

RIHBE 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), and from the Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange

APPEAL RIGHTS:

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

DISCUSSION OF THE EVIDENCE:

The Health Source Rhode Island (HSRI) representative testified:

- Following her complaint, we compared her 2014 income to her current income on file, through a 1040 she provided.
- We determined that the current income was the same for 2015, and that was the income we had correctly used in calculating her APTCs.
- Her tax credits went down from \$506.00 in 2014 to \$446.0 in 2015.
- She asked why the APTCs fell. We determined that this is Federal policy which affects all customers who are signed up through either a state or Federal Marketplace through the ACA and the tax credits necessarily go down every year, and we are unsure of the exact amount they will reduce.
- An email submitted by HSRI post hearing corrected the above statement to indicate that the APTCs do not necessarily decline each year and could theoretically increase depending on both the government's subsidy amounts extended to the customers, as well as the cost of the benchmark plan in that year.
- This current reduction is set by Federal policy and written into the ACA, and HSRI cannot identify the actual policy at this time.
- We will attempt to locate the actual policy for submission into the record.
- The second issue was the issue of the premium for her Blue Cross plan, but we do not have the ability to change the premiums or deductibles which are set by the carriers.
- The Office of Health Insurance Commissioner works with carriers to set rates.
- We are uninvolved with that process in that we cannot dictate rates, or tell them

what to charge customers, but we help administer the plans at the state levels.

- It is frustrating and unfortunate, but we cannot help with the resolution she is seeking.
- The customer's eligibility is determined ahead of time and we send out notice and explain the tax credit which they then apply to their premium choice.
- During open enrollment she was sent a November 19th notice through the mail which asked her for additional annual household income information, and notified her that she qualifies for a maximum credit of \$446.04 per month.

The appellant testified:

- She did not receive a notice about the tax credits before she picked her plan, but was told of the \$446 credits just prior to signing up and prior to choosing her plan which she did in person during open enrollment November 16, 2014.
- She did not yet have a copy of her taxes at that time, as they had not been completed.
- The HSRI representative went through "everything", and tried to go through all the options.
- She informed the representative she wanted to stay away from United Health, and chose not to go to Neighborhood Plus because she was not sure she could keep her current doctors.
- She finally chose Blue Cross to ensure she kept her current doctors and because she was most familiar with that plan.
- She went from a \$500+ deductible to a \$1500 deductible, not because she wanted a better plan, but she because she wanted a lower premium.
- Due to a court order, she gets untaxable income on her tax form from her ex-husband, but it is exactly what she pays per month for premiums, so she uses it directly to pay her bills.
- The only amount he pays is money towards her medical premium until she is eligible for Medicare.
- She chose a higher deductible in order to assist him with lesser premiums, and did not choose a dental plan because it would mean more money for him.

- She knowingly picked the plan, and was aware of what the APTCs would be, but still does not feel the APTCs should have gone up.
- If the premium had stayed the same, she would have stayed with the same deductible and does not feel the insurance rates should have gone up.
- To benefit herself, she also thought she could switch back to the \$500 premium, but is unsure if she would do this if given the opportunity, because his pension was split in half and there are other considerations, and she was being nice.

FINDINGS OF FACT:

- The appellant applied for health insurance at HSRI on November 16, 2014 during open enrollment. She was aware of the APTCs allowed, and chose a carrier, and a premium option at that time.
- A November 19th notice sent to the appellant notified the appellant that additional income information was needed, and notified the appellant the maximum APTC amount would be \$446.04.
- A December 21, 2014 notice informed the appellant she was successfully enrolled in coverage effective January 1, 2015, and that her monthly premium bill would be \$340.21.
- The appellant filed a timely appeal on January 13, 2015.
- A hearing was held on April 30, 2015.
- The hearing was held open until May 13, 2015 for additional information.
- A clarification statement was submitted by HSRI, but no additional evidence was submitted by either party.

CONCLUSION:

Should the appellant's advanced premium tax credits (APTCs) have gone down if her income remained the same?

The appellant re-enrolled for health coverage during open enrollment in 2014. At that time, she went to HSRI, was informed about the amount of her tax credits, researched plans, and premium options, and chose a Blue Cross plan effective on January 1, 2015.

There is no dispute that the appellant herself chose the plan. There is no dispute that she was aware of the amount of the APTCs at the time, and there is no dispute that she was aware of her premium amount prior to choosing her plan.

The appellant argues that she had been told one year prior that her APTC's were related to her income. Because her income did not change, she felt that her APTCs should not have changed-in this case, decreased from \$506 to \$446. In turn, her premium increased, and she chose a higher deductible in order to offset the price of the premium. She further testified that she receives assistance for her premium payment from her ex-husband, and in order to assist him, she kept the premium as low as possible, given the decrease in her APTC assistance. She disputes any decrease in her APTCs and the increase in her premium. She does not dispute her prior knowledge of the APTC and premium amounts before signing up. The Agency presents that the APTCs are used by the Federal government to assist the customer through government subsidies. He testified that Federal policy determines both the increase and decrease in these subsidies which cannot be adjusted by HSRI, and that both state and Federal insurance marketplaces overseen by the ACA come under the Federal policy. Post hearing the Agency further clarified that the APTCs are calculated using the cost of the second-lowest cost silver plan, called a benchmark plan. He testifies that the as the carriers, such as Blue Cross, United, and Neighborhood compete in the marketplace, the lowering of premiums would then affect or lower the federal government's subsidies which assist the customers. He argues that the Office of Health Insurance Commissioner works with the carriers to set rates, and the HSRI is uninvolved with that process in that they do not dictate rates, or tell them what to charge the customer. Instead, he testifies that HSRI helps administer the plans at the state level.

Exploration of the ACA regulations confirms that in order to implement the federal Affordable Care Act (ACA), RI established their own web based system to determine the eligibility for health coverages paid for by Medicaid, or in part, by federal tax credits. The recently established exchange-Health Source Rhode Island (HSRI) uses this new system. Eligibility is determined by an IRS-based measure of income which is then used in determining affordability through the health insurance marketplaces. The advance payment of the premium tax credit (APTC) is a payment made for coverage during the year to an insurance provider which pays for part or all of an applicant's premiums. It is based on the Marketplace's estimate of the tax credit you will be able to take on your tax return. Reconciliation of these tax credits takes place at the end of the year solely through the IRS. In short, the IRS directs the APTC percentages within specific parameters, and these are then calculated and implemented by the exchange. HSRI does not regulate the APTCs. Per regulations, HSRI uses the new eligibility system to make determinations for affordable coverage.

Further exploration of carrier regulations identify that the Exchange (HSRI) does establish a certification process for all their QHP Issuers. The Exchange negotiates, on an annual basis, these agreements with regards to product and/or service offerings. Additionally, the agreements are formed in advance of the Annual Open Enrollment

Period for the upcoming year. Per regulations, the Qualified Health Plan (QHP) offerings may vary from year to year.

Thus, the initial information given the appellant regarding the APTC's being tied to her income is correct in that the amount offered is tied into both the appellant's income, which remained the same, and the marketplace. The APTC's also vary according to percentages set by the Federal Government over which HSRI has no authority. The Marketplace determines and presents their new plans at open enrollment which have already been negotiated and overseen and which also cannot be changed by HSRI.

In summary, the appellant signed up for health coverage during open enrollment in November 2014. She was aware prior to her insurance selection, of the APTCs, and she chose a deductible and premium based upon that information. She thought she should be entitled to the same APTC amounts received the prior year, and disputed the need to have these decrease. The APTC's are regulated by the Federal government, and are also reconciled by them at the end of any given year. The premiums and plan selections are driven by the Marketplace, and these choices are then administered and presented through HSRI. HSRI does not have the authority to change the APTCs, or the premiums and deductibles offered through the carriers. Therefore, HSRI is not responsible for the amount of APTCs offered, nor are they responsible for the amount of the premiums offered. Consequently, the Agency is not responsible for the plan selections and subsequent choices the appellant made for premium, deductible, and plan selections.

After a careful review of the Agency's regulations, as well as the testimony presented, the Appeals Officer finds that the appellant's request for relief is denied.

A handwritten signature in black ink, appearing to read "Karen Walsh", with a long horizontal flourish extending to the right.

Karen Walsh
Appeals Officer

APPENDIX

MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)

1307 “MAGI” Income Eligibility Determinations

1307.01. Scope and Purpose

To implement the federal Affordable Care Act (ACA), Rhode Island took the option under the law to establish its own new web-based eligibility system with the capacity to determine whether an individual or family qualifies for affordable health care coverage paid for by Medicaid or in whole or in part by federal tax credits or other subsidies. The Executive Office of Health and Human Services (EOHHS), the Medicaid Single State Agency, and the recently established Rhode Island Health Benefits Exchange, known as HealthSourceRI (HSRI), are using this new eligibility system to make determinations for all forms of affordable coverage available under the ACA, including Medicaid.

One of the principal goals of the ACA is to improve access to affordable coverage by simplifying and streamlining the application and eligibility determination process. Toward this end, the Act established a distinct income standard – Modified Adjusted Gross Income or MAGI – to determine eligibility for affordable coverage across payers (e.g., Medicaid, tax credits, state subsidies, employers) and populations (families, pregnant women, children, adults without children).

Effective January 1, 2014, the MAGI standard will be used to determine eligibility for all new applicants for Medicaid coverage in the Medicaid Affordable Care Coverage (MACC) groups identified in section 1301 of the Medicaid Code of Administrative Rules (MCAR). The process for applying for Medicaid affordable coverage using the new eligibility system is located in MCAR section 1303.

The purpose of this rule is to: describe the MAGI and explain how it will be applied; and establish the role and responsibilities of the Medicaid agency and consumers when determining MAGI-related eligibility.

1307.02. Definitions

“**Advance payments of the premium tax credit (APTC)**” means payment of the federal health insurance premium tax credit on an advance basis to an eligible person enrolled in a qualified health plan through a health insurance exchange.

“**Affordable Care Act (ACA)**” means the federal Patient Protection and Affordable Care Act of 2010. The law is also sometimes referred to as “Obamacare” and federal health reform.

“**APTC/CSR eligibility**” APTC/CSR eligibility means the application of the IRS-based measure of income known as “Modified Adjusted Gross Income” for determining eligibility for affordable health care through health insurance exchanges/marketplaces established under the ACA. Also, APTC means advanced premium tax credits and CSR means cost sharing reductions.

“**Attestation**” means the act of a person affirming through an electronic or written signature that the statements the person made when applying for Medicaid eligibility are truthful and correct.

“**Caretaker or caretaker relative**” means any adult living with a Medicaid-eligible dependent child that has assumed primary responsibility for that child as defined in MCAR section 1305.13.

“Current Household Monthly Income” means average monthly income from all members determined to be part of the household, received from all sources, and derived during the six-month period ending on the last day of the month preceding application date.

“Custodial parent” means a relationship that is defined by a court order or binding separation, divorce or custody agreement establishing physical custody of a minor child. If no order or agreement exists, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

“Federal poverty level” or **“FPL”**, as used herein, means the most recently published federal poverty level by the U.S. Department of Health and Human Services.

“MAGI” means modified adjusted gross income, adjusted by any amount excluded from gross income under section 911 of the IRS Code, and any interest accrued. Social Security benefits are not included in gross income.

“Medicaid Affordable Care Coverage (MACC) Group” means a classification of persons eligible to receive Medicaid based on similar characteristics who are subject to the MAGI standard for determining income eligibility beginning January 1, 2014.

“Medicaid Code of Administrative Rules (MCAR)” means the compilation of rules governing the Rhode Island Medicaid program promulgated in accordance with the State’s Administrative Procedures Act (R.I.G.L. §42-35).

“Medicaid member” means a person who has been determined to an eligible Medicaid beneficiary.

“New Applicant” means an individual or family that was not enrolled in and receiving Medicaid coverage on the January 1, 2014, effective date this rule. The term does not apply to individual and families who were receiving coverage and where disenrolled for any reason; nor does it apply to parents with income between from 133% to 175% of the FPL who lost eligibility for Medicaid coverage beginning on January 1, 2014 as a result of the eligibility roll-backs mandated under RI law (see Public Law 13-144, section 40-8.4-4 of the Rhode Island General Laws, as amended).

“Non-MAGI Coverage Group” means a Medicaid coverage group that is not subject to the modified adjusted gross income eligibility determination. Includes Medicaid for persons who are aged, blind or with disabilities and persons in need of long-term services and supports as well as individuals who qualify for Medicaid based on their eligibility for another publicly funded program, including children in foster care and anyone receiving Supplemental Security Income (SSI) or participating in the Medicare Premium Assistance Program.

“Relationship-based Household Rules” means the Medicaid household composition rules that consider the living and familial relationships of the applicants without regard to their taxpayer household. Special Medicaid household composition rules result in exceptions to general application of the MAGI Standard.

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE

SECTION 4.0 INITIAL OPEN ENROLLMENT, ANNUAL OPEN ENROLLMENT, AND SPECIAL ENROLLMENT PERIODS

4.1 **In General.** Section 1311 of the ACA and its implementing regulations, 45 C.F.R. §§155.410 and 155.420, establish requirements for initial open enrollment, annual open enrollment, and special enrollment periods for Qualified Health Plans.

4.4 **Annual Open Enrollment Period.**

- (a) *Benefit Year 2015 and Beyond.* For 2015 and subsequent benefit years, the Exchange will establish the annual open enrollment period and shall provide a minimum of one hundred twenty (120) days advance public notice prior to its first day.
- (b) Annual Open Enrollment Periods as established by the Exchange shall last a minimum of thirty (30) days.

4.5 **Annual Open Enrollment Period Coverage Effective Dates.**

- (a) Qualified individuals must select a QHP and the Exchange must receive the first month's premium in full in order to make coverage effective.
- (b) *Benefit Year 2015 and Beyond.* The Exchange shall establish a deadline relative to the Annual Open Enrollment Period by which a qualified individual's first month's premium must be received in order to make coverage effective as of the first day of the benefit year.

SECTION 9.0 AGREEMENTS WITH ISSUERS

9.1 **In General.** The Exchange shall establish a certification process for all participating QHP Issuers.

9.2 **Issuer Agreements.** All QHP Issuers must enter an Issuer Agreement with the Exchange describing the issuer's obligations with regard to offering products and/or services on the Exchange.

- (a) Issuer Agreements shall be negotiated on an annual basis and formed in advance of the Annual Open Enrollment Period for the upcoming benefit year.
- (b) QHPs offered through the Exchange pursuant to an Issuer Agreement may vary from year to 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.