STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: January 23, 2015

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000000984

[redacted]

Dear [redacted]

On November 19, 2014, you appeared by telephone at a hearing on your appeal of NY State of Health Marketplace's September 4, 2014 denial of [redacted] request for reimbursement of Medicare Part C premiums.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this notice.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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Decision

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NY State of Health Number: [redacted]
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[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did the Marketplace properly determine that the Medicaid program should not reimburse the cost of [redacted] Medicare Part C insurance premium?

Procedural History

The Marketplace first received your wife's application for health insurance on June 4, 2014.

On June 7, 2014, an eligibility determination notice was issued. That notice stated that, beginning March 1, 2014, [redacted], your wife, was eligible for benefits through fee-for-service Medicaid. The notice further stated that, because she had Medicare, she could not select a Medicaid Managed Care Plan but that Medicaid might be able to reimburse her for all or part of the Medicare Part B premiums if it was determined to be cost effective.

On June 17, 2014, the Marketplace issued a notice which stated that [redacted] was eligible to receive reimbursement of her Medicare Part B premiums through the New York State of Health.

On June 18, 2014 and June 20, 2014, the Local Department of Social Services issued notices stating that [redacted] was identified "to receive payment(s) or reimbursement of health insurance premiums and/or deductibles, coinsurance, or co-payments" through the Health Insurance Premium Payment program (HIPP).

On September 4, 2014, the Marketplace issued a notice which stated that it was not cost effective for the Medicaid program to pay for [redacted] Medicare Part C health insurance premiums. However, she would continue to receive reimbursement for her Medicare Part B premiums.

On September 12, 2014, you called the Marketplace's Account Review Unit and appealed that determination on [redacted] behalf.

On October 27, 2014, November 6, 2014, November 12, 2014, November 13, 2014, and November 19, 2014, supporting documentation which you had faxed and mailed to the Marketplace was uploaded to your Marketplace account.

On November 18, 2014, the Appeals Unit received a document from the Department of Health's Third Party Liability Unit. The document is entitled "Supporting Documentation to deny payment of Medicare Part C premiums." This document was not made available to you before your hearing.

On November 19, 2014, you had a telephone hearing with a Hearing Officer from the Marketplace's Appeals Unit. The Hearing Officer asked you if you would like to adjourn the hearing to allow you time to review the document that was submitted by the Third Party Liability Unit. You asked that the document be read to you over the phone. After you had heard what the document contained, you stated that you wished to proceed with the hearing. The document was marked as Department of Health's Exhibit #1 and made part of the record. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

A review of the record supports the following findings of fact:

1) You testified that [redacted] was found eligible for Medicare in 2006 and has been enrolled in some form of Medicare Part C, also known as Medicare Advantage, since 2006.

2) You testified and provided evidence that [redacted] has Univera Healthcare as her Medicare Part C plan provider.

3) You testified and provided evidence that the Univera premium was $124.00 per month from March 1, 2014 to July 1, 2014 and $99.20 per month thereafter.

4) Handwritten computation uploaded with copies of checks payable to Univera indicate that the cost of premiums from March 2014 to November 2014 inclusive was $1,016.80.

5) You testified that you began seeking reimbursement for [redacted] Medicare Part C premiums based on the information contained in the June 7, 2014 eligibility determination.

6) You testified that on October 31, 2014 you received a call from the Reimbursement Unit of the Marketplace, which directed you to submit proof that you had made Medicare Part C premium payments to Univera.

7) "Supporting Documentation to deny payment of Medicare Part C premiums," prepared by the Department of Health's Third Party Liability Unit, states: "It is not cost effective for the Medicaid program to pay the Medicare Part C premium payments. This determination was arrived at by comparing what Medicaid paid for co-payments to providers and would have paid for Part C premiums, compared to what Medicaid would have paid if the appellant were not enrolled in Part C. If Medicaid was to pay the Part C premiums in addition to the patient responsibility and Medicare deductibles, it would exceed what Medicaid would have paid if the person was not enrolled in Medicare Part C."

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

The state or local agency administering Medicaid programs must take all reasonable measures to ascertain the legal liability of third parties (42 USC § 1396a(a)(25)). Third parties include health insurers, self-insured plans, group health plans, service benefit plans, managed care plans, etc., that are legally responsible for payment of a claim for a health care item or service (*id.*).

"The [Medicaid] program will pay on behalf of qualified Medicare beneficiaries … the full amount of any deductible and coinsurance costs incurred under Part A or B of Title XVIII of the Social Security Act (Medicare)" (18 NYCRR § 360-7.7(a)).

"Medicare Advantage Plans (sometimes referred to as Medicare Part C or Medicare Managed Care, or Medicare HMOs) are health plan options available to Medicare beneficiaries … If a Medicaid recipient is enrolled in a Medicare Advantage Plan that charges a premium that is higher than the traditional Part B premium, the local district should pay the difference as a health insurance premium, if it is determined to be cost effective" (NYS Department of Health, Office of Health Insurance Programs, "Medicare Advantage Plans and Medicaid Advantage Plans," 09 OHIP/INF-1, March 2, 2009; *see also* NY Social Services Law § 367-a(1)(b), 18 NYCRR § 360-7.4(g)(3)).

Legal Analysis

The matter at issue is whether the Medicaid program should reimburse the health insurance premiums and co-pays that [redacted] has paid and is continuing to pay for her Medicaid Part C coverage through Univera Healthcare.

On June 7, 2014, the Marketplace issued an eligibility determination notice stating that, beginning March 1, 2014, [redacted] was eligible for fee-for-service Medicaid. The notice also stated that, because she had Medicare, she could not select a Medicaid Managed Care Plan but that the Medicaid program might be able to reimburse her for Medicare Part B premiums if it was determined to be cost effective to do so.

In a June 17, 2014 notice, the Marketplace issued a notice stating that [redacted] was eligible for reimbursement of Medicare Part B premiums.

In a September 4, 2014 notice, the Marketplace denied reimbursement for Medicare Part C premiums on grounds that this would not be cost effective for Medicaid.

The record contains a written statement from the Department of Health's Third Party Liability Unit explaining the September 4, 2014 decision to deny reimbursement of the appellant's Medicare Part C premiums and co-pays. In addition to providing a basic discussion to compare the costs, the statement uses data from the appellant's Medicaid claims history to provide examples of the cost differences to Medicaid with and without the appellant's Medicare Part C. Part C coverage for less than one year (March through November 2014), with only three dates of service during that period, costs $1,438.00 (including $1,016 paid to Univera Healthcare) but could have been provided by original Medicaid (Parts A and B) for $205.34.

Therefore, the credible evidence of record shows that it would not be cost effective for Medicaid to reimburse the appellant for the costs of Medicaid Part C coverage that she purchases from Univera Healthcare. Since this would not be cost effective, the Marketplace's September 4, 2014 decision to deny reimbursement is supported by the record and is AFFIRMED.

It should be noted that the June 18, 2014 and June 20, 2014 notices stating that [redacted] was eligible "to receive payment(s) or reimbursement of health insurance premiums and/or deductibles, coinsurance, or co-payments" by the Health Insurance Premium Payment program (HIPP) were not issued by the NY State of Health Marketplace and so cannot be reviewed here.

Decision

The September 4, 2014 notice is AFFIRMED.

Effective Date of this Decision: January 23, 2015

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

[redacted] is eligible for Medicare Part B premium reimbursement but not Medicare Part C premium or co-pay reimbursement.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months after the date of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

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  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The September 4, 2014 notice is AFFIRMED.

This decision does not change your eligibility.

[redacted] is eligible for Medicare Part B premium reimbursement but not Medicare Part C premium or co-pay reimbursement.

Legal Authority

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A Copy of this Decision Has Been Provided To:

[redacted]

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