10-20-2014

Cazier v. Idaho Dept. of Health & Welfare Appellant's Brief Dckt. 42184

IN THE SUPREME COURT OF THE STATE OF IDAHO

CHARLES DRAKE CAZIER

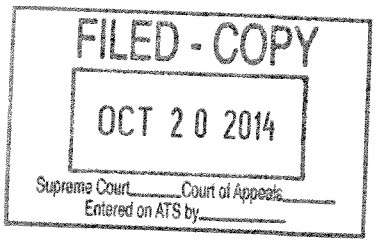
Plaintiff/Appellant

vs.

IDAHO Department OF HEALTH AND WELFARE

Defendant/Respondent

SUPREME COURT
NO.:42184



APPELLANT'S BRIEF

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APPEAL FROM DISTRICT COURT OF THE FIRST JUDICIAL DISTRICT
OF THE STATE OF IDAHO IN AND FOR THE COUNTY OF KOOTENAI
THE HONORABLE JUDGES GASKILL AND KERRICK PRESIDING

Appellant requests a review and remand for correction of A FINAL DECISION AND ORDER that was entered by the Idaho Department of Health and Welfare on May 20, 2013 and confirmed by the district court in MEMORANDUM OPINION AND ORDER ON PETITION FOR JUDICIAL REVIEW rendered on January 27th 2014 and the AMENDED MEMORANDUM OPINION AND ORDER ON PETITION FOR JUDICIAL REVIEW dated February 7, 2014.

History

On May 30, 2003 Cazier, the Appellant, applied to the HIPP program for reimbursement of his wife Carmen Wright's insurance premiums paid to her employer for a family health insurance plan. This health insurance plan covered all of the members of the family regardless of their eligibility for medicaid. Exhibit A (.AGENCY'S RECORD PP 9-15)

Cazier's eligibility in the HIPP program was approved and continued because of the high medical cost of the Appellant's son Clancey who was and is receiving medicaid.

When available from employers Caziers chose to enroll in the most comprehensive family health insurance plan to ensure that Clancey would have access to all medications and medial service to treat his illnesses and disabilities. These policies were not cost effective for the other family members as the high premiums were greater than the benefits paid for all of the other family members.

The State periodically requested and received from Caziers copies of the medical payments made by the insurance company to verify the cost effectiveness to the State. The cost of the family health insurance was always determined to be cost effective.

Enrollment in the HIPP continued for 9 years with the premiums being reimbursed to the Caziers or paid directly by the State for a family health insurance plan..

In late Summer of 2012 the Department requested from Caziers by email the annual medical expenses paid by their private insurance company and the rates for all health insurance plans offered by Mrs. Cazier employer. The Caziers complied.

The Department then decided that even though the Family Health insurance plan was still cost effective the state would only reimburse the Caziers for part of the premium "since Clancey is the only one on Medicaid and is a dependent on Carmen's insurance, the HIPP Program can only reimburse for employee+ child." This was communicated in a very terse manner in an email (last email on Page 76 AGENCY'S RECORD) on September 25, 2012.

This reduction was immediately implemented. A number of emails were exchanged between the Department and Cazier. Cazier was requesting among other things that the decision be in legal form including a notice of the right to appeal and delaying reduction until after a hearing. AGENCY'S RECORD pages 70-76) These requests were ignored, denied or delayed. Even Cazier's filed appeal with the Administrative Procedures Office was like wise denied. The office of

Administrative Procedures based their denial on the fact that the Department had not issued a legal notice of its decision. Cazier sent a letter to the Governor's office (Page 89 AGENCY'S RECORD) which was forward to Richard Armstrong of the Department but no corrective action was taken.

Finally on December 10, 2012 a letter was sent by the Department retroactively reducing the benefit back to September. Cazier immediately appealed the decision. Hearings were held on January 15 and February 5, 2013. With a decision issued on February 19, 2013 in favor of the Department.

A REQUEST FOR REVIEW OF HEARING OFFICER PRELIMINARY DECISION was timely filed and briefs filed by both parties.

A FINAL DECISION AND ORDER was entered by the Department on May 20, 2013.

Appellant timely filed an appeal to the District court.

Petitioner filed a brief and a reply brief and the Department filed a Response Brief in the district court. A Memorandum Opinion and Order on Petition for Judicial Review was rendered on January 27th 2014. In reviewing that decision it was apparent that the court had not read the petitioner's brief. A misfiling by the clerk had prevented the court from receiving the brief. Petitioner filed a motion for reconsideration in the district court. This was denied and the

district court ignored the errors by the Department most pointedly that the decision was based on a false statement and instead ruled that the Department had authority to reduce the reimbursement to a lower cost plan.

STANDARD FOR REVIEW

The standards for review are set forth in Idaho Statues. Specifically at 67-5279. In seeking corrective action of an agency the Appellant must demonstrate that the Department's action has prejudiced his substantial rights.

Secondly, the appellant must demonstrate that the Departments decision or actions were

(a) in violation of constitutional or statutory provisions;

(b) in excess of the statutory authority of the agency;

(c) made upon unlawful procedure:

(d) not supported by substantial evidence in the record as a whole: or

(e) arbitrary, capricious or an abuse of discretion.

If these two requirements are met the court can then exercise it's power to remand the matter back to the Department for corrective action.

Additionally this court is to review the Department's decisions.

Argument

The record is very clear in both the substantial prejudice the appellant has suffered and that the Department has clearly erred in all five of the areas outlined above.

These errors were compounded when the District court ignored the fact the both the Hearing officer and the Department in their review decisions were supported by the evidence in the record as a whole. The hearing officer's decision states on page 2 paragraph 4 (on page 53 of the AGENCY'S RECORD) that: "She (Ronda) argued that it is cost-effective to pay the premium for Carmen and Clancey – the employee plus child coverage tier under her employer's health plan. It is not cost-effective to the State to pay for an increased premium which would cover other members of the family who are not Medicaid eligible – the family coverage tier.". Likewise the Department's final decision states "Since only Clancey was on Medicaid, and it was not cost effective for the state to include the medicaid ineligible family members, the hearing officer appropriately ruled that the cost of any additional insurance coverage of the other family members was not relevant to the HIPP determination. "

These statement are entirely false. Ronda never made the statement that the hearing officer quoted nor anything like it. Even if she had made such a statement it was controverted by the evidence and testimony. Appellant's Exhibits D (Pages 19-23AGENCY'S RECORD) and E (Page 24-33 AGENCY'S RECORD) show the cost of medications and medical services for only Clancey for 1 year. These total $15,451.46 for medications and $6,433.72 in medical treatment. These do not

include the dental and vision treatment cost for Clancey. The Department's exhibit 2 (Page 40 AGENCY'S RECORD) shows the cost of the family insurance premium to be $370.57 semi-month or a total annual premium of $8,893.68. Ronda from the Department had already reviewed these records just prior to her reducing the reimbursement amount and concluded that the payment of the entire family premium was and is cost effective. (her email dated September 27, 2012 In the AGENCY'S RECORD Page 70 top of the page) wherein she is discussing the appeal and States "Your HIPP case with only Clancey on it is currently cost effective and has been so that is not an issue."

In addition to this the Appellant stated frequently in the hearings that the entire family premium was cost effective when only considering the cost saving to the State for Clancey's medical cost. He states the entire family health insurance plan is cost effective for Clancey. He explains this very distinctly. Several times after that in both hearing he again restates that the entire family premium was cost effective for the State. Appellant was a sworn witness at the hearing. (Transcript of hearing Page 9 line 16 through page 10 line 9, page 11 line 10 through page 11 line 22 and page 41 line 7). Never at any point was that statement challenged or controverted. It is beyond imaging where the hearing officer came up with that argument that the family health plan was not cost effective. This was not the determination of the Department and is contrary to all the evidence and testimony.

The District court never acknowledged this fact and instead ruled that the Department could reimburse at a rate lower than the actual cost of the family insurance plan.. This was an argument

that Ronda of the Department had made before the Hearing officer and Marlene Klein also of the Department argued in her brief in the Department review. Neither the hearing officer nor the Department accepted this argument and stated their sole reason for denying the appeals was because the family insurance plan was not cost effective. This cost effective issue is what the District court should have reviewed and which the Appellant now pleads this court to consider and remand the matter back to the Department with instructions that the evidence clearly shows the Family insurance plan is cost effective. The court may also want to instruct the Department that it's regulations do not supercede the Federal mandates IE 42 USC 1397ee(c)(3) on reimbursement of family insurance plans.

Continuing with the requirements for this court to correct the errors of the Department, the substantial prejudice is nearly self evident in that the Department has reduced the reimbursement for the privately purchased insurance to less than one-third of the cost of the insurance. So the substantial prejudice is approximately $500.00 per month..

Secondly, the Department was in violation of statutory provisions on at least two points. 42 USC 1396e (c) reads in pertinent part:

"(B) If all members of a family are not eligible for medical assistance under this subchapter and enrollment of the members so eligible in a group health plan is not possible without also enrolling members not so eligible—

(i) payment of premiums for enrollment of such other members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking into account

payment of all such premiums), but

(ii) payment of deductibles, coinsurance, and other cost-sharing obligations for such other members shall not be treated as payments for medical assistance for eligible individuals. "

Further 1397ee(c)(3) states that"(3) Waiver for purchase of family coverage

Payment may be made to a State under subsection (a)(1) of this section for the purchase of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income children only if the State establishes to the satisfaction of the Secretary that——

(A) purchase of such coverage is cost-effective relative to——

(i) the amount of expenditures under the State child health plan, including administrative expenditures, that the State would have made to provide comparable coverage of the targeted low-income child involved or the family involved (as applicable); or

(ii) the aggregate amount of expenditures that the State would have made under the State child health plan, including administrative expenditures, for providing coverage under such plan for all such children or families; and

(B) such coverage shall not be provided if it would otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage."

Although the State of Idaho has established a program of reimbursement of privately purchased insurance under the HIPP program the Department in this case chooses after over 9 years of paying for family insurance plan not to follow the statute by reducing the reimbursing to the

premium of another less expensive policy.

These statutes do not mention partial payment of premiums, partial reimbursement of premium payment nor the State selecting the policy. It is very clear in stating "the medicaid agency pays **all** premiums," and "medicaid agency pays premiums for enrollment of other family members when cost-effective.". In the subject case the premium has always been for a family health plan. An employee and child is not what was purchased. It is a family health plan. No where in these statutes or regulations is the Department allowed to pick what plan is purchased nor dictate that it will only pay what would be paid under some other health plan. The rule is clear that (i) payment of premiums for enrollment of such other [family] members shall be treated as payments for medical assistance for eligible individuals, if it would be cost-effective (taking in to account payment of **all** such premiums),"

There is no ambiguity in these laws nor any mention of partial payment. The term repeatedly used is "ALL".

If that were not enough 1397ee(c)(3)"Waiver for purchase of family coverage" which the Hearing officer's decision cites, clearly states "Payment may be made to a State under subsection (a)(1) of this section for the purchase of family coverage under a group health plan or health insurance coverage..."

Additionally the Department was in violation of the statutory provisions by ignoring § 431.230 Maintaining services. Which states in part; "(a) If the agency mails the 10-day or 5-day notice as

required under § 431.211 or § 431.214 of this subpart, and the recipient requests a hearing before the date of action, the agency may not terminate or reduce services until a decision is rendered after the hearing unless—

(1) It is determined at the hearing that the sole issue is one of Federal or State law or policy; and

(2) The agency promptly informs the recipient in writing that services are to be terminated or reduced pending the hearing decision. "

On page 58 0f the AGENCY'S RECORD the Hearing officer stated after citing the above regulation that;"The hearing officer concludes that § 431.230 does apply in this action, as if falls under the fair hearing procedures set forth as Subpart E of the State Organization and General Administration of Medicaid. Because the date of action – reducing services – was prior to the hearing date, the Department was obligated to continue services pending the outcome of this appeal. "

Nevertheless the Department ruled in it's FINAL DECISION AND ORDER, that;

Base upon the guidance and interpretation published by CMS, the hearing officer erred in concluding that the federal notice provisions applied in these proceeding. For this reason, Paragraphs 3 and 4 of the hearing officer's Conclusions of Law Preliminary Order, PP. 7-8 are reversed and set-aside."

No guidance nor interpretation published by CMS has ever been entered into evidence nor put forth in any previous oral presentation or testimony. It can not just suddenly appear in the

Department's review decision.

Third; the Department was in excess of their statutory authority. As cited above 42 USC 1396e (c) and 42 USC 1397ee(c)(3) the state is given authority to establish a reimbursement plan for the purchase of private insurance. They are not giving authority for partial reimbursement. This is what the Department wished to do in this case and it is clearly in excess of the Department's statutory authority. Likewise the Department can not chose the policy purchased. Their role is to determine if the entire premium is cost effective.

Appellant has been unable to find any state or federal court decisions ruling on these Federal statutes. This lack of judicial review is evidence that the statutes are so clear in their language that no state has ever challenged it in a court proceeding.

The Department's decision and implementation were made upon unlawful procedure First the emailed notice of a change in benefits was not mailed nor was any notice of the right to appeal or to continue to receive benefits pending a hearing conveyed to the Caziers. Second, when a notice was finally mailed in December it had an effective date of September. These actions and inactions were a complete abortion of the State IDAPA and the Federal medicaid law that are in place to avoid this exact type of action.

The decision to reduce the reimbursement rate was arbitrary, capricious and an abuse of discretion. For over nine years the Department had reimbursed at the family insurance rate per 42 USC 1397ee(c)(3). Then suddenly the Department changed it's mind and decides that the reimbursement rate was being reduced because two of the children were no longer eligible for medicaid. This was immaterial as the rate is the same for 1 child or more. This is clearly shown on the rate card exhibit 2 (Page 40 AGENCY'S RECORD). Ronda finally agreed with that in her email of September 25, 2012 (Second email on Page 70 AGENCY'S RECORD). Still the Department immediately reduced the payment. Then arbitrarily sent a letter on December 10th notifying of a reduced rate. This action of post dating a change in benefits is also an abuse of discretion.

CONCLUSION

The Departments decisions are based a the false idea that the family health plan coverage is not cost effective. Neither the hearing officer nor the Department presented any other interpretation of the clear language of the statutes nor reason for reducing the reimbursement rate from a family rate to some other rate.

The Department's actions and decisions are clearly sufficient for this court to remand the matter back to the Department. Then the Department can render a decision based on the fact that the family health premium is cost effective and hold a hearing to determine if in fact the cost to the family for the insurance plan is a higher cost for the family policy than is shown on the rate card

because of the use of BENEFLEX dollars.

Respectfully submitted

C. Drake Cazier

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing Appellant's Brief was

___X_____mailed, with first class postage prepaid thereon;

_____hand delivered;

_____ Emailed

on the 17 th day of October, 2014 TO:

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