11-18-2014

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

IN THE SUPREME COURT OF THE STATE OF IDAHO

CHARLES DRAKE CAZIER, Petitioner-Appellant, vs. IDAHO DEPARTMENT OF HEALTH AND WELFARE, Defendant-Respondent.	)	SUPREME COURT DOCKET NO. 42184 KOOTENAI COUNTY NO. CV 2013-4504

RESPONDENT'S RESPONSE BRIEF TO APPELLANT

APPEAL FROM THE DISTRICT COURT OF THE FIRST JUDICIAL DISTRICT OF THE STATE OF IDAHO, IN AND FOR THE COUNTY OF KOOTENAI

HONORABLE JAY GASKILL
DISTRICT COURT JUDGE PRESIDING

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I. STATEMENT OF THE CASE

A. Nature of the Case:

This is an appeal form the state of Idaho, Department of Health and Welfare's (Department) decision to reduce the insurance premium reimbursement made to the Cazier family under the Health Insurance Premium Payment program (HIPP).

B. Course of Proceedings:

Mr. Cazier (Cazier) and his wife, Carmen Wright, have several children and had been participating in the HIPP under a family-tier reimbursement plan. In September 2012, the Department determined that there was only one child that was a remaining Medicaid eligible member of the family. On December 10, 2012, Cazier received a notice from the Agency advising that the Health Insurance Premium Program (hereafter HIPP) reimbursement would be changing due to the number of people eligible for Medicaid in the household and cost effectiveness.

Cazier submitted a timely request for fair hearing. An evidentiary hearing was held on January 15 and February 5, 2013. The hearing officer issued the Findings of Fact, Conclusions of Law, and Preliminary Decision on February 19, 2013 that affirmed the Department's decision to reduce the HIPP reimbursement to Cazier. He requested a timely administrative review pursuant to Idaho Code §67-5245. On May 16, 2013, the Director's Office entered a Final Decision and Order affirming the hearing officer's decision. Cazier then filed a Petition for Judicial Review of the Director's Decision. On January 29, 2014, a Memorandum Opinion and Order on Petition for Judicial Review

was entered. It was amended by the Court and entered on February 7, 2014. Both decisions upheld the decision made by the Department. Cazier then filed a motion for reconsideration of the Amended Memorandum Opinion and Order entered by the District Court. On April 11, 2014, the District Court entered a Memorandum Opinion and Order on Motion to Reconsider denying the motion for reconsideration and affirming the Amended Memorandum Opinion Order on Petition for Judicial Review filed on February 7, 2014.

C. Statement of Facts

Cazier and his wife, Carmen Wright, (Wright) have several children. Wright, Cazier and the children were being covered through the insurance program offered through Wrights' employer. The family had been participating in the HIPP under a family-tier reimbursement plan. In September, 2012, it was determined that only one child remained Medicaid eligible. The Department determined that the medical insurance program available to Wright through her employer offered coverage for the employee and one child. The premium for this coverage was substantially reduced from that premium for the family-tier coverage. The Department, on or about September 20, 2012, then sent written notice to Cazier and Wright that effective October 1, 2012, the HIPP would no longer reimburse at the family-tier rate, but that all future reimbursement would be at the employee-one child rate.

The Department determined that the HIPP reimbursement reduction was not a benefit change and therefore not subject to an appeal for a fair hearing. Nevertheless, the Department sent a letter on December 10, 2012 re-advising Cazier of its decision to

reduce the amount of HIPP reimbursement to the employee-one child premium and it provided a notice of appeal if the Department's decision was disagreed with.

II. ISSUE ON APPEAL

1. Did the Department's *Final Decision and Order* correctly uphold the Department's decision to reduce the insurance premium reimbursement payment under the HIPP?

III. STANDARD OF REVIEW

Judicial review of the Department's decision is limited by the Idaho Administrative Procedures Act. Specifically, the Court shall not substitute its judgment for that of the agency as to the weight of the evidence on questions of fact. Idaho Code §67-5279(1). Further, the Court shall affirm the agency action unless the Court finds the decision was (1) in violation of constitutional or statutory provisions, (2) in excess of the statutory authority of the agency, (3) made upon unlawful purpose, (4) not supported by substantial evidence on the record as a whole; or (5) was arbitrary, capricious, or an abuse of discretion. Idaho Code §67-5279(3).

> The standard of judicial review of an agency action is prescribed by statute. Under the Idaho Administrative Procedures Act, a reviewing court is required to affirm the agency's decision unless its findings, inferences, conclusions, or decisions are: (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 on the record as a whole; or (e) arbitrary, capricious, or an abuse of discretion. I.C. § 67-5279(3). Accordingly, this Court defers to the agency's findings of fact unless they are clearly erroneous. *Lane Ranch P'ship. v. City of Sun Valley,* 144 Idaho 584, 588, 166 P.3d 374, 378 (2007) (citing *Friends of Farm to Market v. Valley County,* 137 Idaho 192, 46 P.3d 9 (2002)). Further, the agency decision must prejudice a substantial right of the Appellant. I.C. § 67-5279(4); *Price v. Payette County Bd of County*

Comm'rs, 131 Idaho 426, 429, 958 P.2d 583, 586 (1998) 166 P.3d 374, 378 (2007) (citing *Friends of Farm to Market v. Valley County,* 137 Idaho 192, 46 P.3d 9 (2002)).

Kootenai Medical Center, ex rel. Teresa K. v. Idaho Department of Health and Welfare, 147 Idaho 872 216 P.3d 630 (Idaho 2009).

IV. ARGUMENT

A. Health Insurance Premium Program Background (HIPP)

The HIPP reimbursement program is designed to save Medicaid costs by providing insurance premium payment reimbursement if it meets the cost-effective requirements. The relevant federal authority for HIPP and the definitions, in pertinent part are as follows:

> **42 U.S. Code § 1396e (c) - Enrollment of individuals under group health plans** (emphasis added)
>
> (a) Requirements of each State plan; guidelines (underline added)
>
> Each State plan—
>
> (3) may implement guidelines established by the Secretary, consistent with subsection (b) of this section, to identify those cases in which enrollment of an individual otherwise entitled to medical assistance under this subchapter in a group health plan (in which the individual is otherwise eligible to be enrolled) is cost-effective (as defined in subsection (e)(2) of this section);
>
> (2) may require, in case of an individual so identified and as a condition of the individual being or remaining eligible for medical assistance under this subchapter and subject to subsection (b)(2) of this section, notwithstanding any other provision of this subchapter, that the individual (or in the case of a child, the child's parent) apply for enrollment in the group health plan; and
>
> (3) in the case of such enrollment (except as provided in subsection (c)(1)(B) of this section), shall provide for payment of all enrollee premiums for such enrollment and all deductibles, coinsurance, and other cost-sharing obligations for items and services otherwise covered under the State plan under this subchapter (exceeding the amount otherwise permitted under section 1396o of this title), and shall treat coverage under

the group health plan as a third party liability (under section 1396a (a)(25) of this title). ....

(b) Premiums considered payments for medical assistance; eligibility (underline added)

(1)

(A) In the case of payments of premiums, deductibles, coinsurance, and other cost-sharing obligations under this section shall be considered, for purposes of section 1396b (a) of this title, to be payments for medical assistance.

(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.

(2) The fact that an individual is not enrolled in a group health plan under this section shall not change the individual's eligibility for benefits under the State plan, except insofar as section 1396(a)(25) of this title provides that payment for such benefits shall first be made by such plan.....

(e) Definitions (underline added)

In this section:

(1) The term "group health plan" has the meaning given such term in section 5000(b)(1) of the Internal Revenue Code of 1986, and includes the provision of continuation coverage by such a plan pursuant to title XXII of the Public Health Service Act [42 U.S.C. 300bb–1 et seq.], section 4980B of the Internal Revenue Code of 1986, or title VI of the Employee Retirement Income Security Act of 1974.

(2) The term "cost-effective" has the meaning given that term in section 1397ee (c)(3)(A) of this title.

42 U.S. Code § 1397ee(c)(3) Waiver for purchase of family coverage (emphasis added)

> 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;

42 U.S. 1396e (c), (e) and 1397ee(c)(3).

The state through the Idaho Administrative Procedures Act states that participants must apply for and enroll in a cost-effective group health plan if one is available:

> GROUP HEALTH ENROLLMENT. Title XIX and Title XXI participants must apply for and enroll in a cost-effective group health plan if one is available. A cost-effective health plan is one which has premiums and co-payments at a lower cost than Medicaid would pay for full medical services. Medicaid will pay premiums and other co-payments for plans the Department finds cost effective.

IDAPA 16.03.01.280

B. The Department correctly applied the HIPP requirements in reducing the amount of reimbursed insurance premiums to Cazier

Although eligibility for the HIPP program is not at dispute here, a little background may be helpful to the Court. In this case there were originally three children who were eligible for Medicaid. It was cost effective to have them participate in the HIPP program. The Cazier's previous HIPP reimbursement was directly tied to that eligibility coupled with the cost effectiveness to the state to do so. The number of

children eligible for Medicaid reduced to one. That change in Medicaid eligibility triggered a review of the HIPP reimbursement. There is no dispute in the record that only one child remains eligible for Medicaid. Nor is there any dispute that the HIPP continues to be cost effective for the state for that one child. Cazier's argument is that the Department incorrectly applied the law in reducing the insurance reimbursement amount to the employee and one child tier. The Department disagrees.

Once the Department determined that only one child remained eligible for Medicaid it reviewed the medical insurance plan that was being reimbursed under the HIPP. The employer's insurance had various tiers of coverage. One of the tiers offered allowed the employee and one child to be covered under the plan. The insurance provider advised the Department that this tier was eligible to Wright. The Department was provided the amount of the monthly premium for the employee one child tier. The Department concluded that since the employer's insurance plan had a tier that covered the employee and one child it would be reimbursing at this rate based upon the federal guidelines listed above. The Department advised Cazier that the amount to be reimbursed under HIPP for the monthly insurance premium would be the cost of insurance coverage for the employee and one child as of October 1, 2012. ER Exhibit 1, p.98-99 (Bates 49-50).

Cazier argues that the law requires the Department to continue to pay the family tier coverage insurance premium whether or not the other members of the family are eligible. Essentially he wants the Department to continue to cover his medical insurance as well as Wright and the eligible child. He is in incorrect. The Department correctly determined that the employer's insurance could provide coverage for just the employee

(Wright) and the one child remaining eligible for Medicaid and was provided the cost of providing that coverage. ER Tr. p. 38-39 L. 21-5. ER Exhibit 2, p. 89-94 (Bates 40-45). It followed the federal law as required. If the employer's insurance did not offer the employee and one child tier as an option for coverage then the state would be required pay the family tier insurance premium, which included ineligible Medicaid members if it continued to be cost effective to do so. The Department did not have to consider this calculation as the employer was able to provide the cost of the insurance premium for the employee and one child.

C. HIPP reimbursement is not a Medicaid benefit requiring the Department to continue paying the reimbursement at the original rate pending appeal

It is not clear from Cazier's briefing whether he is actually appealing the issue of whether or not he was entitled to a notice that provided appeal notification and/or continuing payment of HIPP reimbursement at the original rate pending appeal.

In an abundance of caution the Department will address the issue of continued HIPP reimbursement at the original rate pending appeal. The Final Decision and Order found that the hearing officer wrongly concluded that HIPP reimbursements were Medicaid Benefits and subject to continuing payments during the pendency of the appeal.

> The hearing officer wrongly concluded that 42 CFR §431.230 applies to the HIPP and disregarded the guidance issued by the Centers for Medicare and Medicaid Services ("CMS"). As part of the state-federal partnership in administering the Medicaid program, CMS issues guidance and federal regulations that clarify the appropriate interpretation and application of the applicable provisions. CMS provided guidance in Regional Medicaid Letter no. 94-78 concerning the applicability of hearing, notice and continuance of services provision in relation to the program at issue in this case and found that these requirements are not applicable because reimbursement of premium payments under HIPP are not deemed Medicaid "services" as that term is define in the federal regulations.

ER p. 156- 157 (Bates 106-107).

The District Court affirmed the agency action in its Memorandum Opinion and Order on Motion to reconsider after review of the entire record. AR p. 100. The District Court considered the record as a whole and affirmed the agency decision based upon the statutory requirements. Idaho Code §67-5279(3), id.

CONCLUSION

On appeal, the Court must affirm the Department's decision unless one of the five conditions set forth in Idaho Code § 67-5279(1) are met. In this case, the Department did not violate constitutional or statutory provisions, did not act in excess of its authority and did not act upon an unlawful purpose. The decision of the hearing officer was supported by the substantial evidence and was not arbitrary, capricious or an abuse of discretion. Therefore, the hearing officer's decision must be affirmed.

RESPECTFULLY SUBMITTED this 17th day of November, 2014.

DENISE L. ROSEN
Deputy Attorney General

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that on this 17th day of November, 2014, I caused to be served a true and correct copy of the foregoing by the following method to:

Mr. C. Drake Cazier
3025 West Summer Avenue
Athol, ID 83801

☒ U.S. Mail
☐ Hand Delivery
☐ Certified Mail, Return Receipt Requested
☐ Overnight Mail

Ronda Mein
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