STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. L-02/18-126
	)	
Appeal of	)	
	)	

INTRODUCTION

Petitioner appeals the denial by the Department of Vermont Health Access (Department) of her request that she be credited for alleged overpayment of Dr. Dynasaur premiums in 2017; the Department argues that it correctly relied on information submitted by petitioner, and also, that the appeal is untimely. The following facts are adduced from documents submitted by the Department on February 16th and May 7, 2018, telephone hearings held May 10th and July 12, 2018, supplemental filings by the Department on July 24th and October 19th, and by the petitioner on November 1, 2018.

FINDINGS OF FACT

1. Dr. Dynasaur is Vermont's low-cost or free health coverage plan for children under the age of 19 whose household income is below 312 percent of the Federal Poverty Limit (FPL).

2. Two of petitioner's minor children have been enrolled in Dr. Dynasaur, or its precursor program, Vermont Health Access Plan (VHAP), for many years.

3. The issue in this case is that, as further outlined below, petitioner was invoiced by the Department and paid for Dr. Dynasaur premiums for April - December 2017 coverage in the amount of $60/month which was the uninsured or primary coverage rate rather than the $20 rate for secondary coverage. Petitioner asserts that from 2002 forward the two children have been covered by their father's insurance as primary coverage and that Dr. Dynasaur coverage was only secondary insurance. Petitioner is divorced from the children's father and he lives out of state.

4. At hearing, the Department stated that prior to 2013 its records indicate that the children were covered by their father's insurance as primary coverage and Dr. Dynasaur was listed as secondary coverage.

5. However, in 2013, when the Department's VHAP records were changed over to the Vermont Health Connect (VHC) system, the Department required that petitioner reapply for Dr. Dynasaur. The Department submitted a copy of the application that petitioner completed on-line on October 27, 2013, in which petitioner stated that she was covered by

Medicaid and the children were covered by Dr. Dynasaur and did not identify any other insurance coverage. The Department submitted subsequent applications filed on March 31, 2014, December 6, 2014, and March 20, 2015 (two applications and the last application on file). On all these applications, in response to questions about whether anyone in the household was eligible to receive insurance from an employer or other source, petitioner had indicated "no". In other words, in these applications, petitioner did not identify that the children had primary insurance coverage with their father. On that basis, the Department stated that its records indicate, from 2013 forward, that Dr. Dynsaur was the children's primary insurance. Billing records for 2013 - 2014 were not provided.

6. From 2013 and to date petitioner reported many income changes to the Department; she was sometimes covered by Medicaid and sometimes on a VHC Qualified Health Plan; thus, the amount of her invoices for health coverage fluctuated.

7. The Department's case notes reflect that after a conversation with petitioner on March 14, 2016 Department staff realized that it had been billing the Dr. Dynasaur premium at $0 since 2015, instead of the $15/month premium

Dr. Dynasaur amount due during that time. Subsequently, the Department processed a passive renewal of the household's health coverage and corrected the oversight in its system and issued a Notice of Decision dated December 17, 2016. In that decision, the two minor children are identified as being eligible for Dr. Dynasaur, with the notation "uninsured" under the eligibility determination. This decision contained a provision that notified petitioner of her right to appeal the redetermination. After this decision, it took time to correct the billing process, so petitioner was not invoiced for any Dr. Dynasaur premiums until she received the invoice for April 2017 coverage.

8. In the invoice dated March 5, 2017 (for April coverage), in addition to her QHP premium, petitioner for the first time was billed for a $60 Medicaid/Dr. Dynasaur premium for her two minor children. This $60 premium represented the rate for primary insurance coverage instead of a $20 rate for secondary coverage. Invoices for May - December 2017 coverage were likewise billed at the $60 premium amount.

9. Department's case notes reflect that there were various conversations between the petitioner and the Department in December 2017 in which petitioner questioned the amount of premiums she had paid. The Department's case

notes reflect that on December 12, 2017, the petitioner affirmatively reported that the children were on their father's insurance and that Dr. Dynasaur coverage should only be listed as secondary coverage. Because of this conversation, the Department processed a change to a $20 Dr. Dynasaur premium. The change could not be processed for January or February 2018 coverage, but petitioner correctly paid the January - February invoices and her Dr. Dynasaur account was credited for the $40 monthly difference for those months. Thus, the dispute of alleged overbilling is for April - December 2017 coverage months ($40/month x 9 months = $360).

10. Petitioner seeks a credit to her Dr. Dynasaur account for the alleged overbilling. The Department argues that the application questions were clear, that petitioner had post-application phone interviews with Department staff to review the content of the applications and that it was entitled to rely on petitioner's statements. And, the Department argues that petitioner's February 1st appeal is untimely as the December 2016 decision regarding reenrollment for 2018 coverage clearly listed the children as "uninsured" and eligible for Medicaid/Dr. Dynasaur. Further the monthly

invoices from April – December 2017 each listed a $60-line item specifically for the Dr. Dynasaur premium.[1]

11. Petitioner argues that the questions on the online application were ambiguous or alternatively that the applications that were submitted were "auto-generated" by the Department and petitioner didn't sign them and should not be held responsible. Petitioner also argues that Dr. Dynasaur has never been billed as the primary insurance, a fact confirmed by the Department post-hearing. Further, she argues that she had no way to know that the premium was being overbilled. Petitioner testified that due to errors in Departmental billing over the years, and frequent changes in her income, her total invoice frequently fluctuated and she had no way of knowing that the $60 amount was the incorrect rate.

12. The evidence demonstrates that the 2013 - 2015 on-line applications were completed by the petitioner and that post-application interviews with the Department also occurred

[1] Based on the state of the evidence, a ruling on the Department's argument that the appeal is untimely is reserved. While the December Notice of Decision identified the children as 'uninsured', it did not identify the amount of the Dr. Dynasaur premium owed. As the evidence supports a finding that the Department's actions in April - December 2017 were proper based on the information provided by petitioner, the appeal is decided on that basis.

and that petitioner did not report, in either instance, that the children had other primary insurance.

ORDER

The Department's decision is affirmed.

REASONS

Review of the Department's determination is de novo. The Department has the burden of proof at hearing if terminating or reducing existing benefits; otherwise the petitioner bears the burden. *See* Fair Hearing Rule 1000.3.0.4.

The Department's Health Benefits Eligibility and Enrollment (HBEE) Rules outline the process for appealing the amount of a Medicaid premium as follows

> If an individual subject to a premium appeals a decision by AHS that . . . increases the amount of their Medicaid premium, the individual must continue to pay the premium amount in effect prior to the decision that resulted in their appeal in order to have their Medicaid coverage continue pending the outcome of the appeal.
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> HBEE Rules §64.13 [Appeal of Medicaid premium amount].
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> Medicaid premium payment balances that result from . . . overpayments will be credited to the premium payer's account and will be applied to subsequent Medicaid premium bills.

> Rules §64.10 [Medicaid premium payment balances}.
>
> An individual must request a fair hearing within 90 days from the date that notice of decision is sent by AHS (see §68.01(b)(1)).
>
> Rules §80.04(l) [Request for hearing].

Petitioner filed a request for fair hearing on February 1, 2018. It is unfortunate that there was confusion regarding the issue of primary versus secondary coverage when the applications were filed and also that petitioner did not understand that she was being overbilled from April - December 2017. However, the questions regarding alternative health insurance coverage were clear and petitioner did not dispute the Department's assertion that there were also post-application interviews in which the information on the application(s) was confirmed. The Department is entitled to rely on the information provided in the applications. And, the Department corrected the billed amount after it was informed by petitioner on December 12, 2017 that the Dr. Dynasaur coverage should be billed as secondary insurance.

On that basis, the Department's decision to deny petitioner's request for a credit to her Dr. Dynasaur account is affirmed. *See* 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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