Index to Appendices

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UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No: 22-2948

Michael J. Harvey, SSA #3FT6-GWO-RG70

Appellant

v.

Xavier Becerra, Department of Health and Human Services, Sec. for DHHS

Appellee

Appeal from U.S. District Court for the District of Minnesota
(0:21-cv-02693-ECT)

ORDER

The petition for rehearing en banc is denied. The petition for rehearing by the panel is also denied.

August 31, 2023

Order Entered at the Direction of the Court:
Clerk, U.S. Court of Appeals, Eighth Circuit.

/s/ Michael E. Gans

United States Court of Appeals
For the Eighth Circuit

No. 22-2948

Michael J. Harvey, SSA #3FT6-GWO-RG70

Plaintiff - Appellant

v.

Xavier Becerra, Department of Health and Human Services, Sec. for DHHS

Defendant - Appellee

Appeal from United States District Court
for the District of Minnesota

Submitted: April 21, 2023
Filed: April 26, 2023
[Unpublished]

Before GRUENDER, GRASZ, and KOBES, Circuit Judges.

PER CURIAM.

Michael Harvey appeals the district court's[1] dismissal of his pro se civil action for lack of subject matter jurisdiction. Upon careful de novo review, *see Hastings v.*

[1]The Honorable Eric C. Tostrud, United States District Judge for the District of Minnesota.

Wilson, 516 F.3d 1055, 1058 (8th Cir. 2008) (explaining that this court reviews de novo the grant of a motion to dismiss for lack of subject matter jurisdiction), we affirm for the reasons stated by the district court. *See* 8th Cir. R. 47B.

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No: 22-2948

Michael J. Harvey, SSA #3FT6-GWO-RG70

Plaintiff - Appellant

v.

Xavier Becerra, Department of Health and Human Services, Sec. for DHHS

Defendant - Appellee

Appeal from U.S. District Court for the District of Minnesota
(0:21-cv-02693-ECT)

JUDGMENT

Before GRUENDER, GRASZ, and KOBES, Circuit Judges.

This appeal from the United States District Court was submitted on the record of the district court and briefs of the parties.

After consideration, it is hereby ordered and adjudged that the judgment of the district court in this cause is affirmed in accordance with the opinion of this Court.

April 26, 2023

Order Entered in Accordance with Opinion:
Clerk, U.S. Court of Appeals, Eighth Circuit.

/s/ Michael E. Gans

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A UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

Michael J. Harvey,

Plaintiff,

v.

Xavier Becerra, Department of Health and Human Services, Sec. for DHHS,

Defendant.

File No. 21-cv-2693 (ECT/JFD)

OPINION AND ORDER

Michael J. Harvey, pro se.

Liles Harvey Repp, United States Attorney's Office, Minneapolis, MN, for Defendant Xavier Becerra.

In late 2016, Plaintiff Michael J. Harvey discovered that his Medicare Part B coverage had lapsed for nonpayment of premiums. His odyssey to correct this situation in the face of what can only be characterized as bureaucratic incompetence gives rise to this lawsuit. Defendant has filed a motion to dismiss for lack of subject-matter jurisdiction, and the motion will be granted. Though every citizen can likely sympathize with Harvey's experience, there is no federal jurisdiction to remedy his claimed damages.

I

On November 28, 2016, Harvey received a bill from the Social Security Administration, which is an agency of the Department of Health and Human Services.

Compl. [ECF No. 1] ¶ 17.[1] The charges on this bill were $265.40 for the last quarter of 2016, and $402.00 for the first quarter of 2017. *Id.* Harvey mailed a payment of $350.00 to the agency on December 18, 2016. *Id.* ¶ 18. The agency, however, did not process this payment until December 29, 2016. *Id.* ¶ 19.

The bill Harvey received provided that payment was due by December 25, 2016. *Id.* ¶ 18. On December 28, 2016, the agency sent Harvey notice that because he had not timely paid the charges, his Part B coverage would expire at the end of December 2016. *Id.* ¶ 21. Harvey received another letter from the agency on January 10, 2017, informing Harvey that his premium for 2017 was $134.00 per month, as had been stated on the November 2016 bill. *Id.* ¶ 27. This letter did not reference Harvey's payment. *Id.*

Harvey filed a request for reconsideration of the expiration of his coverage in February 2017. *Id.* ¶ 28. He noted that the agency had never confirmed that he had made a payment in December 2016, nor had it sent him new insurance cards that its communications promised to send, and he objected to paying any additional premiums until the payment confusion was resolved. *Id.* ¶¶ 30–32.

In February and March, Harvey twice attempted to make a $150.00 payment using the same credit card he had used to make his December payment. *Id.* ¶ 38. The agency rejected each attempted payment, saying that the credit-card account number was invalid. *Id.*

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[1] The facts are as described in the complaint. The administrative record has not yet been filed. *See* ECF No. 28.

In April, Harvey received yet another letter from the agency, claiming that he owed $351.40 for January through March 2017, and stating that because he had not paid, his last month of coverage was March 2017. *Id.* ¶¶ 35–37. Harvey points out that his $350.00 payment in December 2016 included $84.60 to be applied to 2017 premiums, so the most he should have owed for the first quarter of 2017 was $317.40. *Id.* ¶ 36.

In a telephone call with the agency after receiving the April letter, Harvey ostensibly asked for Part B coverage to begin in July 2017. *Id.* ¶ 43. Although there is apparently an application for this coverage in the administrative record, Harvey claims that the representative either misunderstood or purposefully misrepresented his request. *Id.* ¶¶ 43, 46. He insists that he believed he had been covered by Part B since 2013, when he first became eligible for those benefits and that he did not ask for coverage to begin in July 2017. *Id.* ¶ 47.

A week later, Harvey received another letter from the agency, stating that he was eligible for monthly retirement benefits in July 2017, and that his Part B coverage would start in July 2018. *Id.* ¶ 50. On May 6, 2017, Harvey received a written response to his request for reconsideration. *Id.* ¶ 57. This letter acknowledges that the agency received a payment in December 2016, but reaffirms the agency's decision to end Harvey's Part B coverage as of March 2017, because he had ostensibly only paid another $100.00 toward his $402.00 quarterly premium. *Id.* ¶ 60. The letter did not mention Harvey's attempts to pay $150.00 in March 2017. *Id.* The agency again stated that Harvey did not currently have Part B coverage, but that future Part B premiums would be deducted from his monthly retirement benefits. *Id.* ¶ 62. The letter also told Harvey that, if correspondence from the

agency had caused confusion that resulted in Harvey losing continuous Part B coverage, he could apply for equitable relief. *Id.* ¶ 61.

In the late summer and fall of 2017, Harvey received several communications from the agency, each stating a different date for his Part B coverage eligibility. *Id.* ¶¶ 72–73, 78–79, 85. In the meantime, Harvey had applied for equitable relief, been told in a phone call that his request for equitable relief had been denied, and then received a letter stating that his Part B coverage began in July 2013 but that he owed an additional $254.60 for past-due premiums, which would be deducted from his benefit check, making his check $790.40. *Id.* ¶¶ 72–73. But later in August, an agency employee told Harvey that his entire check would be garnished for unpaid premiums. *Id.* ¶ 74. Harvey alleges that he did not receive a check for benefits in August 2017. *Id.* ¶ 77. He did, however, receive a check for September 2017, as well as a "refund" of $643.60. *Id.*

In late August, Harvey enlisted the offices of U.S. Senator Amy Klobuchar to attempt to resolve the issue. *Id.* ¶ 75. He thereafter received another letter from the agency, dated September 18, 2017, stating that he would receive the aforementioned refund. *Id.* ¶ 78. This letter also stated that the agency had changed the date of Harvey's entitlement to Part B benefits to July 2017, "as [he] requested." *Id.* ¶ 79. Harvey contends that he did not request any such change. *Id.* The agency reiterated this change in entitlement date, as well as Harvey's refund, in an October 29, 2017, letter. *Id.* ¶ 85. In a gross understatement, the agency conceded that its communications could have led to Harvey being unsure about the status of his Part B coverage. *Id.* ¶ 86.

The saga continued with Harvey filing two requests for reconsideration—one in December 2017 and one in March 2018. *Id.* ¶ 104. These requests were both denied, although according to Harvey the agency continued to state incorrectly that he had requested the July 2017 Part B re-enrollment date and also continued to make mistakes in the amounts he allegedly owed. Harvey contended then and asserts in this lawsuit that the agency still owes him money. *Id.* ¶ 113.

Harvey appealed the denials of his requests for reconsideration, claiming that the agency still owed him $310.56. *Id.* ¶¶ 144, 155. He also requested $10,000 for his time and expenses pursuing the matter before the agency. *Id.* ¶ 146. An Administrative Law Judge held a hearing on his claims; he describes the ALJ's findings in detail in his allegations. He does not, however, state clearly what the ALJ decided with regard to amounts owed. He was apparently dissatisfied with the outcome, however, because he took an appeal to the Medicare Appeals Council. *See id.* ¶ 185 (stating that paragraphs 7 through 184 of the Complaint "are a slight revision of the appeal (submitted in August of 2019) that I presented to the . . . Medicare Appeals Council"). The Appeals Council denied Harvey's appeal, finding that he had "not demonstrated that he is due additional equitable relief beyond what has already been provided . . . ." *Id.* ¶ 189. This lawsuit followed.

Harvey's complaint asserts that there is federal question jurisdiction under 28 U.S.C. § 1331, relying on the Social Security Act's judicial review provision, 42 U.S.C. § 405(g), the False Claims Act, and the Debt Collection Improvement Act of 1996. [ECF No. 1 at 6.] He seeks an order overturning the ALJ's decision "concerning my request for reimbursement of 1221.96 for alleged overpayments of Medicare Part B premiums." *Id.*

at 7. As "additional relief" he asks for $10,000 as requested in his initial appeal, and another $90,000 "as penalty for the SSA's and Medicare's illegal, fraudulent, deceptive, erroneous, misrepresentative, harassing, prejudicial, manipulative, and corrupt conduct in their handling of the cancellation of my Medicare Part B account . . . and the illegal confiscation of my benefits." *Id.*

The agency now moves to dismiss, arguing that there is no subject-matter jurisdiction over Harvey's claims. In response, Harvey contends that his claims include violations of his constitutional rights, making the exercise of jurisdiction appropriate.

II

A court reviewing a motion to dismiss for lack of subject-matter jurisdiction under Rule 12(b)(1) must first determine whether the movant is making a "facial" attack or a "factual" attack. *Branson Label, Inc. v. City of Branson*, 793 F.3d 910, 914–15 (8th Cir. 2015). A facial attack is one made on the basis of the pleadings alone and is determined by evaluating the allegations regarding jurisdiction in the complaint. *Id.* A factual attack, on the other hand, relies on matters outside the pleadings. The agency's motion accepts Harvey's allegations as true, and thus is a facial attack.

In a facial attack, "the court merely [needs] to look and see if plaintiff has sufficiently alleged a basis of subject matter jurisdiction." *Menchaca v. Chrysler Credit Corp.*, 613 F.2d 507, 511 (8th Cir. 1980). Similar to a motion under Rule 12(b)(6), in considering a facial attack, the plaintiff's allegations are accepted as true and all reasonable inferences are drawn in his favor. *Gorog v. Best Buy Co.*, 760 F.3d 787, 792 (8th Cir. 2014) (citation omitted).

"Federal courts are courts of limited jurisdiction." *Gunn v. Minton*, 568 U.S. 251, 256 (2013) (quotation omitted). This limited jurisdiction holds true for federal judicial review of agency decisions. *See, e.g.*, 5 U.S.C. § 706(2)(A) (providing that a court may set aside certain agency decisions only if they are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"). Congress sets the parameters of such review, and whether couched as claims under the respective reviewing statute or another federal law, judicial review is limited to what Congress allows.

In the Medicare Act, Congress expressly limited judicial review of decisions of the Center for Medicare and Medicaid Services such as those about which Harvey complains. 42 U.S.C. § 1395ff(b)(1)(A) (providing for judicial review "as is provided in [42 U.S.C.] section 405(g)"); *see also id.* § 405(g) (judicial review of agency decisions limited to determining whether "substantial evidence" supports that decision). As relevant here, the statute does not allow judicial review of claims for less than $1,760. *Id.* § 1395ff(b)(1)(D) (setting initial amount in controversy at $1,000), § 1395ff(b)(1)(E)(iii) (providing that amount in controversy is indexed to inflation); *see also* 85 Fed. Reg. 60795, 60796 (setting judicial review amount for 2021 at $1,760).

Harvey has not alleged sufficient damages to allow judicial review of his claims. *See* Compl. ¶¶ 144, 155 (asserting that the agency owes Harvey $310.56). Subject-matter jurisdiction is therefore lacking, and this matter must be dismissed. *See Acquisto v. Secure Horizons ex rel. United Healthcare Ins. Co.*, 504 F. App'x 855, 856 (11th Cir. 2013) ("Because [the plaintiff] has not met the amount in controversy requirement [in

§ 1395ff(b)(1)(D)], the district court properly dismissed . . . for lack of subject matter jurisdiction.").

Harvey's request for an additional $100,000 in penalties "to deter altogether any recurrence of the ignoble and destructive acts [the agency] has committed in this case," Compl. at ECF p. 7 ("Request for Relief"), does not save his claims because monetary damages are not available under the statute. *See* 42 U.S.C. § 405(g) (providing that a court may enter a judgment "affirming, modifying, or reversing the decision" but making no provision for money damages).

Harvey's response to the motion to dismiss argues that the agency violated his rights under the Constitution. Any constitutional claims would fail for at least four reasons. *First*, Harvey's complaint does not mention the Constitution as a source of his claims, and a litigant may not amend his pleadings in his brief in response to a dispositive motion. *Morgan Distrib. Co. v. Unidynamic Corp.*, 868 F.2d 992, 995 (8th Cir. 1989) ("[I]t is axiomatic that a complaint may not be amended by the briefs in opposition to a motion to dismiss."). *Second*, had Harvey properly amended his claims to raise constitutional issues, he would not be entitled to money damages for those alleged constitutional violations. *Schweiker v. Chilicky*, 487 U.S. 412, 424 (1988) ("The [Social Security] Act, however, makes no provision for remedies in money damages against officials responsible for unconstitutional conduct that leads to the wrongful denial of benefits."). *Third*, Harvey's due process claim seems self-defeating. Harvey relies primarily on the Supreme Court's decision in *Goldberg v. Kelly*, 397 U.S. 254 (1979), which found that welfare recipients possessed a property right in their benefits that could not be terminated without due

process. *Id.* at 262–63. He contends that, because he did not receive a hearing before his Part B benefits were terminated, his due-process rights were violated. But as Harvey concedes, he did receive notice that his benefits would be terminated if he did not pay; it was his attempt to pay that began the bureaucratic snafu Harvey experienced. In other words, assuming Harvey had a protected property interest in his Part B benefits, "the question remains what process is due." *Cleveland Bd. of Educ. v. Loudermill*, 470 U.S. 532, 541 (1985). The Constitution does not prohibit the government from depriving a citizen of a property interest; it prohibits only those deprivations accomplished without some sort of pre-deprivation process. "Due process requires notice 'reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.'" *United Student Aid Funds, Inc. v. Espinosa*, 559 U.S. 260, 272 (2010) (quoting *Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314, (1950)). Harvey alleges that he received such notice here. *Fourth*, because all of Harvey's potential constitutional claims are intertwined with his claims under the Medicare Act, there is no subject-matter jurisdiction over those claims. Harvey asserts that the agency administered his claim erroneously because of "alleged bias and incompetence . . . [which] is simply a claim that [he was] entitled to" a refund of premiums paid for benefits he did not receive. *United States v. Bushman*, 862 F.2d 1327, 1329 (8th Cir. 1988). But this is "a claim not cognizable by this court." *Id.*; *see also Heckler v. Ringer*, 466 U.S. 602, 614 (1984) (noting that beneficiaries' challenge to the agency's procedure for reaching a decision in a Medicare Act case was "inextricably intertwined" with their claim for benefits and therefore not "cognizable in federal district court by way

of federal-question jurisdiction"). Distilled to their essence, Harvey's claims are that the agency erroneously (and in his mind, fraudulently and deceptively) determined his eligibility for Part B benefits. These claims arise under the Medicare Act. Because the money Harvey claims to be owed does not reach the statutory jurisdictional threshold, there is no federal-question jurisdiction to resolve his claims.

ORDER

Based on the foregoing, and all of the files, records, and proceedings herein, **IT IS ORDERED** that:

1. Defendant's Motion to Dismiss [ECF No. 19] is **GRANTED**.

2. The Complaint [ECF No. 1] is **DISMISSED without prejudice** for lack of subject matter jurisdiction.

LET JUDGMENT BE ENTERED ACCORDINGLY.

Dated: August 25, 2022

s/Eric C. Tostrud
Eric C. Tostrud
United States District Court

UNITED STATES DISTRICT COURT

District of Minnesota

Michael J. Harvey,

Plaintiff(s),

v.

Xavier Becerra, Department of Health and Human Services, Sec. for DHHS,

Defendant(s).

JUDGMENT IN A CIVIL CASE

Case Number: 21-cv-2693 (ECT/JFD)

☐ **Jury Verdict.** This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

☒ **Decision by Court.** This action came to trial or hearing before the Court. The issues have been tried or heard and a decision has been rendered.

IT IS ORDERED AND ADJUDGED THAT:

1. Defendant's Motion to Dismiss [ECF No. 19] is GRANTED.

2. The Complaint [ECF No. 1] is DISMISSED without prejudice for lack of subject matter jurisdiction.

Date: 8/26/2022

KATE M. FOGARTY, CLERK

UNITED STATES COURT OF APPEALS
FOR THE EIGHTH CIRCUIT

No: 22-2948

Michael J. Harvey, SSA #3FT6-GWO-RG70

Appellant

v.

Xavier Becerra, Department of Health and Human Services, Sec. for DHHS

Appellee

Appeal from U.S. District Court for the District of Minnesota
(0:21-cv-02693-ECT)

ORDER

The motion of appellant for an extension of time until July 3, 2023, to file a petition for rehearing and to file an overlength petition for rehearing is granted.

Electronically-filed petitions for rehearing must be received in the clerk's office on or before the due date.

The three-day mailing grace under Fed.R.App.P. 26(c) does not apply to petitions for rehearing.

May 23, 2023

Order Entered at the Direction of the Court:
Clerk, U.S. Court of Appeals, Eighth Circuit.

/s/ Michael E. Gans

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Eighth Circuit Court of Appeals

PRO SE Notice of Docket Activity

The following was filed on 05/15/2023

Case Name: Michael Harvey v. Xavier Becerra
Case Number: 22-2948

Docket Text:
MOTION for extension of time to file petition for rehearing until 07/03/2023 and to file an overlength petition for rehearing, filed by Appellant Michael J. Harvey w/service by USCA8 05/15/2023. [5277146] [22-2948]

The following document(s) are associated with this transaction:
Document Description: Motion for extension of time and to file overlength petition

Notice will be mailed to:

Michael J. Harvey
Apt. 206
2520 County Road F, E.
White Bear Lake, MN 55110

Notice will be electronically mailed to:

Mr. Liles Harvey Repp: liles.repp@usdoj.gov,
usamn.ecfeighth@usdoj.gov,caseview.ecf@usdoj.gov,abigail.barr@usdoj.gov

United States Court of Appeals
For The Eighth Circuit
Thomas F. Eagleton U.S. Courthouse
111 South 10th Street, Room 24.329
St. Louis, Missouri 63102

Michael E. Gans
Clerk of Court

VOICE (314) 244-2400
FAX (314) 244-2780
www.ca8.uscourts.gov

April 26, 2023

Michael J. Harvey
Apt. 206
2520 County Road F, E.
White Bear Lake, MN 55110

RE: 22-2948 Michael Harvey v. Xavier Becerra

Dear Mr. Harvey:

The court today issued an opinion in this case. Judgment in accordance with the opinion was also entered today.

Please review Federal Rules of Appellate Procedure and the Eighth Circuit Rules on post-submission procedure to ensure that any contemplated filing is timely and in compliance with the rules. Note particularly that petitions for rehearing and petitions for rehearing en banc must be received in the clerk's office within 45 days of the date of the entry of judgment. Counsel-filed petitions must be filed electronically in CM/ECF. Paper copies are not required. Except as provided by Rule 25(a)(2)(iii) of the Federal Rules of Appellate Procedure, no grace period for mailing is allowed. Any petition for rehearing or petition for rehearing en banc which is not received within the 45 day period for filing permitted by FRAP 40 may be denied as untimely.

Michael E. Gans
Clerk of Court

HAG

Enclosure(s)

cc: Ms. Kate M. Fogarty
Mr. Liles Harvey Repp

District Court/Agency Case Number(s): 0:21-cv-02693-ECT

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Wilson, 516 F.3d 1055, 1058 (8th Cir. 2008) (explaining that this court reviews de novo the grant of a motion to dismiss for lack of subject matter jurisdiction), we affirm for the reasons stated by the district court. *See* 8th Cir. R. 47B.

Supreme Court of the United States
Office of the Clerk
Washington, DC 20543-0001

Scott S. Harris
Clerk of the Court
(202) 479-3011

January 3, 2024

Mr. Michael Harvey
2520 County Road F, East
#206
Saint Paul, MN 55110

Re: Michael J. Harvey
v. Xavier Becerra, Secretary of Health and Human Services
Application No. 23A506

Dear Mr. Harvey:

The application for a further extension of time in the above-entitled case has been presented to Justice Kavanaugh, who on January 3, 2024, extended the time to and including January 28, 2024.

This letter has been sent to those designated on the attached notification list.

Sincerely,

Scott S. Harris, Clerk

by

Angela Jimenez
Case Analyst

Supreme Court of the United States
Office of the Clerk
Washington, DC 20543-0001

Scott S. Harris
Clerk of the Court
(202) 479-3011

December 5, 2023

Mr. Michael Harvey
2520 County Road F, East
#206
Saint Paul, MN 55110

Re: Michael J. Harvey
v. Xavier Becerra, Secretary of Health and Human Services
Application No. 23A506

Dear Mr. Harvey:

The application for an extension of time within which to file a petition for a writ of certiorari in the above-entitled case has been presented to Justice Kavanaugh, who on December 5, 2023, extended the time to and including January 22, 2024.

This letter has been sent to those designated on the attached notification list.

Sincerely,

Scott S. Harris, Clerk

by

Clayton Higgins
Case Analyst

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MIME-Version:1.0 To:mndecfnotifications@mnd.uscourts.gov Message-Id:<8430713@mnd.uscourts.gov> Subject:Activity in Case 0:21-cv-02693-ECT-JFD Harvey v. Becerra Order on Motion to Dismiss/General Content-Type: text/html

This is an automatic e-mail message generated by the CM/ECF system. Please DO NOT RESPOND to this e-mail because the mail box is unattended.
*****NOTE TO PUBLIC ACCESS USERS*** Judicial Conference of the United States policy permits attorneys of record and parties in a case (including pro se litigants) to receive one free electronic copy of all documents filed electronically, if receipt is required by law or directed by the filer. PACER access fees apply to all other users. To avoid later charges, download a copy of each document during this first viewing. However, if the referenced document is a transcript, the free copy and 30 page limit do not apply.**

U.S. District Court

U.S. District of Minnesota

Notice of Electronic Filing

The following transaction was entered on 8/25/2022 at 4:25 PM CDT and filed on 8/25/2022

Case Name: Harvey v. Becerra
Case Number: 0:21-cv-02693-ECT-JFD
Filer:
WARNING: CASE CLOSED on 08/25/2022
Document Number: 38

Docket Text:
OPINION AND ORDER. Defendant's Motion to Dismiss [19] is GRANTED. The Complaint [1] is DISMISSED without prejudice for lack of subject matter jurisdiction. LET JUDGMENT BE ENTERED ACCORDINGLY. Signed by Judge Eric C. Tostrud on 8/25/2022. (KMW)

0:21-cv-02693-ECT-JFD Notice has been electronically mailed to:

Liles Harvey Repp liles.repp@usdoj.gov, caseview.ecf@usdoj.gov, tara.sheqem@usdoj.gov

0:21-cv-02693-ECT-JFD Notice has been delivered by other means to:

Michael J. Harvey
2520 County Road F., East, #206
Saint Paul, MN 55110

The following document(s) are associated with this transaction:

Document description: Main Document
Original filename:n/a
Electronic document Stamp:
[STAMP dcecfStamp_ID=1051215216 [Date=8/25/2022] [FileNumber=8430711-0
] [b558be00a9ce7f91089b971c6dc27d08a4b013c6e107b9d3c3bad1f76308a4f7d7b
5993c45bbb4d81545e9c1dab6970c688ca7b444c0e5cb4ec81b3b6c0fe5d6]]

(1)

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Secretary

Departmental Appeals Board, MS 612
Medicare Appeals Council
330 Independence Avenue
Cohen Building, Room G-644
Washington, DC 20201
(202)565-0100/Toll Free:1-866-365-8

Docket Number: M-19-2771
ALJ Appeal Number: 1-8022619361

Michael Harvey
2520 Country Road F, E. #206
Saint Paul, MN 55110

NOTICE OF DECISION OF MEDICARE APPEALS COUNCIL

What This Notice Means

Enclosed is a copy of the decision of the Medicare Appeals Council. If you have any questions, you may contact the Centers for Medicare & Medicaid Services regional office or the local Medicare contractor.

Your Right to Court Review

If you desire court review of the Council's decision, you may commence a civil action by filing a complaint in the United States District Court for the judicial district in which you reside or have your principal place of business. *See* § 1869(b) of the Social Security Act, 42 U.S.C. § 1395ff(b). The complaint must be filed within sixty days after the date this letter is received. 42 C.F.R. § 405.1130. It will be presumed that this letter is received within five days after the date shown above unless a reasonable showing to the contrary is made. 42 C.F.R. § 405.1136(c)(2).

If you cannot file your complaint within sixty days, you may ask the Council to extend the time in which you may begin a civil action. However, the Council will only extend the time if you provide a good reason for not meeting the deadline. Your reason must be set forth clearly in your request. 42 C.F.R. § 405.1134.

If a civil action is commenced, the complaint should name the Secretary of Health and Human Services as the defendant and should include the Council's docket number and ALJ

appeal number shown at the top of this notice. 42 C.F.R. § 405.1136(d). The Secretary must be served by sending a copy of the summons and complaint by registered or certified mail to the General Counsel, Department of Health and Human Services, 200 Independence Avenue, S.W., Washington, D.C. 20201. In addition, you must serve the United States Attorney for the district in which you file your complaint and the Attorney General of the United States. *See* rules 4(c) and (i) of the Federal Rules of Civil Procedure and 45 C.F.R. § 4.1.

This notice and enclosed order were mailed on: October 18, 2021.

Enclosure

cc: Social Security Administration
Mid-America Program Service Center

(1)

DEPARTMENT OF HEALTH AND HUMAN SERVICES
DEPARTMENTAL APPEALS BOARD
Medicare Appeals Council
Docket No. M-19-2771

M.H., Appellant
ALJ Appeal No. 1-8022619361

DECISION

The Administrative Law Judge (ALJ) issued a decision dated June 28, 2019, concerning the appellant's request for reimbursement of $1,221.96 for alleged overpayments of Medicare Part B premiums as well as other relief. The ALJ determined that there was no basis for granting the appellant's request for reimbursement or other forms of relief. The appellant has asked the Medicare Appeals Council (Council) to review the ALJ's decision.

The Council reviews the ALJ's decision *de novo*. 42 C.F.R. § 405.1108(a). The Council enters the appellant's request for review; subsequent correspondences dated September 17, 2019, July 14, 2020, and May 3, 2021; as well as congressional inquiry correspondence dated July 23, 2021, and August 3, 2021, into the record as Exhibits (Exhs.) MAC-1 through MAC-5, respectively.

As explained below, we adopt the ALJ's decision.

DISCUSSION

The Council has carefully considered the record, including the hearing testimony and the appellant's contentions and finds that the appellant has not demonstrated that he is due additional equitable relief beyond what has already been provided by the Social Security Administration (SSA).

At the outset, we acknowledge the appellant's multiple complaints and assertions of mistake, bias, and misrepresentation, as well as the appellant's exceptions to many of the ALJ's findings of fact, contending that the inaccuracy of the ALJ's interpretation of his case are determinative to the ALJ's unfavorable decision, and allegations that the record is incomplete. Exh. MAC-1 at 16-63. First, the Council has reviewed the record, including the audio transcript of the ALJ pre-hearing conference, ALJ hearing, and the claim file, and find the record to be complete. The documents that the appellant contends are not in the record appear in the record before the Council. *See, e.g.*, Exh. 4 at 84-107.

And while we acknowledge the ALJ's attempts to obtain records from SSA, specifically SSA's response, if any, to the appellant's August 2017 request for equitable relief, we find the record includes SSA's response dated, October 29, 2017. *Compare* Exh. 4 at 79, *with* Exh. 1 at 6. As such, we find harmless the SSA's seeming lack of response to the ALJ's request. Second, to the extent that the ALJ may have made typographical errors or the ALJ's findings of fact may not have reflected the appellant's interpretation of the events or the law, or to the extent that the appellant has misunderstood or misinterpreted the ALJ's summary, those errors are harmless as they do not change the outcome of this appeal.

Section 1837(h) of the Social Security Act (Act) authorizes equitable relief only if an individual's enrollment or non-enrollment in Medicare Part B is unintentional or erroneous on the basis of error, misrepresentation, or inaction of an officer, employee, or agent of the Federal Government. *See also* Program Operations Manual System (POMS) Hospital Insurance (HI) § 00805.170. Allegations of error, misrepresentation, or inaction of a Federal agent must be supported by documentary evidence. *Id.* § 00805.175; *see also* Act § 1837(h). Additionally, the error, misrepresentation, or inaction by the officer, employee, or agent must result in prejudice to the individual's rights. POMS HI § 00805.170. Examples of prejudice include carrying private insurance the individual did not need; electing surgery in advance of entitlement because of misinformation about entitlement date; missing an enrollment period; inability to pay a large premium arrearage which accrued due to government delay; or any other hardship with health insurance or health care needs that is traced to government error, misrepresentation, or inaction on enrollment, premium collection, or termination or entitlement. *Id.*

At issue here, after a complicated history of Part B enrollment and disenrollment, is the appellant's request for equitable relief filed with the SSA on August 3, 2017. Exh. 4 at 65-68. In that request, the appellant asserted the SSA's confusing correspondence led him to believe that he did not have Part B coverage during the first half of 2017. *Id.* The appellant proposed that he be re-enrolled in Part B as of July 2017, that he pay no premium for January 2017 through June 2017, and that $450.00 that he paid during the first half of 2017 be applied to premiums due in July and going forward. *Id.*

The SSA responded to the appellant's request, granting some of the equitable relief requested by the appellant. In correspondence dated October 29, 2017, the SSA responded to the appellant's request providing a history of the appellant's correspondence to the SSA and its responses. Exh. 1 at 6-10. The SSA acknowledged that its previous correspondence with the appellant was vague and granted the appellant's request for Medicare Part B enrollment, beginning July 2017. *Id.* at 7. In addition, the SSA concluded that the appellant was owed $643.40 in overpaid premiums. In coming to this amount, the SSA provided a breakdown of all premiums owed and paid from July 2013, through September 2017. *Id.* The appellant disagreed with the equitable relief provided by the SSA and appealed its initial determination setting forth costs and premiums the

appellant believes he is still owed. The SSA concluded that the appellant is not entitled to additional reimbursement, a conclusion with the which the ALJ agreed. Exh. 1 at 3-5, ALJ Decision (Dec.).

We clarify that there is no dispute that the appellant was entitled to equitable relief pursuant to the Act. *See, e.g.*, Exh. 1 at 6. Rather, the issue is whether the SSA's calculation of refund owed to the appellant was incorrect and whether the appellant is entitled to additional reimbursement. For the following reasons, the Council finds that the appellant has not demonstrated that the SSA erred in calculating the refund owed to him or that he is entitled to additional equitable relief.

As previously stated, the SSA's October 29, 2017, letter included a detailed breakdown of overages and arrearages beginning in June 2013, when the appellant was first covered under Medicare Part B. *Id.* at 7-9. The history is extensive, and we find it unnecessary to repeat it here. *Id.* We note that the appellant does not dispute the payment history set forth by the SSA, including the premiums still owed by the appellant through December 2016, for a total of $544.80. *Id.* at 8. In March 2017, while not enrolled in Part B, the appellant made a payment of $100.00, which the SSA applied to the arrearage, reducing the amount owed by the appellant to $444.80, which, again, the appellant does not dispute that he owed for previous past due premiums. *Id.* at 8; Exh. MAC-1 at 49.[1]

Per the appellant's request Part B coverage was reinstated beginning in July 2017. Exh. 4 at 65. On this point, we acknowledge that both the SSA and ALJ mistakenly stated that the appellant did not owe a premium for July 2017. This is incorrect because the appellant's enrollment began in July 2017 and, therefore, the appellant owes the premium. As we explain shortly, the misstatement alone is insufficient to find that the appellant is owed the July 2017 premium.

Returning to the amount owed to the appellant, the appellant's monthly benefits for July and August 2017, totaled $2358.00. *Id.* From that amount the SSA deducted $402.00, representing premiums for July, August and September 2017, which, again, per the appellant's request that he be enrolled in Part B beginning July 2017, is correct. Exh. 4 at 110; *see also* Exh. 1 at 8 (explaining that Part B premiums are one month in advance). In addition, the SSA should have deducted only $444.80 for past due premiums, which should have resulted in the appellant being owed $1,511.20 ($2,358 (monthly benefits) - $402 (July-September 2017 premiums - $444.80 (past due premiums). However, as the SSA acknowledged, the SSA mistakenly only paid the appellant $867.60, based on its

[1] We note that the appellant indicates in his original request for relief that he made a total of $450.00 in payments from February to April 2017; however, in his request for review the appellant states that two attempted payments of $150.00 did not go through. Exh. MAC-1 at 22-23. Therefore, we find the SSA's crediting of only $100.00, the payment made in March 2017, is correct. We note also that the appellant now indicates that he understands the $100.00 was applied to his outstanding balance and does not seek reimbursement for that amount. *Id.* at 55.

miscalculation that the appellant owed $1,088.40 in past due premiums. Exh. 1 at 8. As a result, the SSA refunded the appellant an additional $643.60. *Id.* at 9.

The appellant's bank statement supports that the SSA paid him $643.60. Exh. MAC-1 at 65. We also note that the appellant's bank statement shows that the SSA paid him $790.40 in September 2017, which corresponds with the information contained in SSA's October 2017 letter. *Id.* On the other hand, we agree with the appellant the bank statement does not reflect an SSA payment of $77.20, which its October 2017 letter indicates was paid in August 2017. *Id.* at 64; Exh. 1 at 8. The bank statement, however, begins at August *4*, 2017. Exh. MAC-1 at 64. Moreover, the SSA's payment history reflects a payment of $77.20, paid in August 2017. Exh. 1 at 48. Because the appellant's evidence does not encompass the entire month of August 2017 and the record contains evidence that SSA paid $77.20 in August 2017, we find that the appellant has not demonstrated that the SSA did not pay him the $77.20 identified in its October 2017 letter.

In sum, we find no error in the SSA's calculation of the amount owed to the appellant for overpaid premiums and find that the appellant has not demonstrated that he was underpaid the amount owed to him.

Regarding the appellant's request for refunds of his July 2017 premium and partial August 2017 premium, we find no basis on which to award reimbursement for these amounts. Exh. MAC-1 at 55-57, 59. Again, as SSA explained in its October 29, 2017 letter to the appellant, the SSA reinstated the appellant's Part B coverage as of July 2017, per the appellant's request. Exh. 1 at 8; Exh. 4 at 65. The appellant does not offer evidence that he was misled by SSA as to whether he had coverage for that period. To the contrary, the record evidence supports that the SSA informed him of his Medicare insurance beginning in July 2017. Exh. 1 at 11; *see also id.* at 29-30 (indicating the appellant request benefits beginning in July 2017). Moreover, the appellant has neither argued nor submitted evidence that he was prejudiced or harmed by the alleged misdeeds of the SSA. For example, the appellant does not allege that he had to obtain private insurance, elected surgery in advance of entitlement because of misinformation about entitlement date, missed an enrollment period, was unable to pay a large premium arrearage which accrued due to government delay, or experienced any other hardship with health insurance or health care needs that is traced to government error, misrepresentation, or inaction. POMS (HI) § 00805.170. Thus, we find the record does not support any error, misrepresentation or inaction by the SSA or other Federal agent regarding the appellant's Part B enrollment beginning in July 2017 or any resulting prejudice to the appellant.

Finally, and for similar reasons, we disagree that the appellant is entitled to additional relief beyond the overpaid premiums already refunded to him. For example, while the appellant indicates that he took out a loan as a result of SSA's errors, which was not fully

(5)

repaid until July 2018, the appellant offers no evidence of the loan. Exh. MAC-1 at 58. Nor does the appellant specify the harm incurred as a result of obtaining the loan. Similarly, other than indicating that he has suffered financial duress and personal affront, the appellant does not identify the specific harms he incurred. As such, we find the appellant has offered no basis for additional relief.

DECISION

The Council adopts the ALJ's decision. The appellant is not entitled to equitable relief beyond what has already been granted by the SSA.

MEDICARE APPEALS COUNCIL

Debbie K. Nobleman
Administrative Appeals Judge

Date: October 18, 2021

Department of Health and Human Services
OFFICE OF MEDICARE HEARINGS AND APPEALS
Irvine, California

Appeal of:	**M. HARVEY**	OMHA Appeal No.:	**1-8022619361**
Enrollee:	**M. HARVEY**	Medicare:	**Entitlement**
Medicare No.:	*****8406A**	Before:	**Kevin M. McCormick** Administrative Law Judge

DECISION

An **UNFAVORABLE** decision is against the Appellant, M. Harvey.

Procedural History

The Social Security Administration (SSA) terminated the Appellant's Medicare Part B benefits because the Appellant failed to pay the premiums due. The Appellant requested equitable relief from SSA and SSA established a Part B stop date of December 2016 and reinstated the Appellant's Part B benefits in July 2017. The Appellant now seeks reimbursement of Part B premium payments made in 2017.

The Appellant's request for a hearing before an Administrative Law Judge (ALJ) was timely filed with the Office of Medicare Hearings and Appeals (OMHA) and the amount in controversy met the jurisdictional requirements. *See* 42 C.F.R. § 405.1006.

The procedural history of this case is:

1. On October 30, 2018, a Notice of Hearing was sent informing the Appellant of a December 5, 2018 hearing (Exh. 4, p. 1).
2. On November 13, 2018, the Appellant waived the right to an ALJ hearing in response to the Notice of Hearing (Exh. 4, p. 8).
3. On November 20, 2018, I denied the request for a decision on the record and informed the Appellant that the hearing remained scheduled on December 5, 2018 in order to clarify issues in the case (Exh. 4, p. 11).
4. On December 3, 2018, the Appellant requested a continuance of the December 5, 2018 hearing because he needed additional time to prepare for the hearing (Exh. 4, p. 19).
5. On December 4, 2018, a Notice of Re-scheduled Hearing was sent to the Appellant for a January 9, 2019 hearing (Exh. 4, p. 12).

23, 2005). The ALJs within OMHA issue binding decisions of the Secretary, unless later reviewed by the Medicare Appeals Council. *Id.*

B. Scope of Review

The issues before the ALJ include all the issues brought out in the initial, reconsidered or revised determination that were not decided entirely in the Appellant's favor. However, if evidence presented before or during the hearing causes the ALJ to question a fully favorable decision he or she will notify the Appellant and will consider it an issue at the hearing. 42 C.F.R. § 405.1032(a).

C. Standard of Review

The ALJ conducts a de novo review of each claim at issue and issues a decision based on the hearing record. 42 C.F.R. § 405.1000(d) and Section 557 of the Administrative Procedure Act. De novo review requires the ALJ to review and evaluate the evidence without regard to the findings of prior determinations on the claim and make an independent assessment relying upon the evidence and controlling laws. All laws and regulations pertaining to the Medicare and Medicaid programs, including, but not limited to Titles XI, XVIII, and XIX of the Social Security Act and applicable implementing regulations, are binding on ALJs. 42 C.F.R. § 405.1063.

The burden of proving each element of a Medicare claim lies with the Appellant by preponderance of the evidence (i.e. satisfied through the submission of sufficient evidence in accordance with Medicare rules). *See* Sections 1814(a)(1), 1815(b), and 1833(e) of the Act; 42 C.F.R. § 424.5(a)(6), 42 C.F.R. § 405.1018, 42 C.F.R. § 405.1028, and 42 C.F.R. § 405.1030.

Unless the ALJ dismisses the hearing, the ALJ will issue a written decision that gives the findings of fact, conclusions of law, and the reasons for the decision. 42 C.F.R. § 405.1046(a). The decision must be based on evidence offered at the hearing or otherwise admitted into the record. *Id.*

II. Principles of Law

A. Statutes and Regulations

To be eligible for Supplementary Medical Insurance (SMI) benefits, an individual must either (a) be entitled to hospital insurance under Part A of Title XVIII, or (b) attain the age of 65 and be a resident of the United States, either a citizen, or an alien lawfully admitted for permanent residence who has resided in the United States continuously during the five (5) years immediately preceding the month in which he or she applies for enrollment under Part B. Act § 1836; 42 U.S.C. § 1395o; 42 C.F.R. § 407.10(a).

Congress established a Medicare enrollment process detailed at Section 1837 of the Act, 42 U.S.C. § 1395p. An individual may enroll in the insurance program established by this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this section. If an individual is eligible for enrollment and satisfies paragraph (1) or (2) of section 1836 on or after March 1, 1966, his initial enrollment period shall

- Because of administrative fault, delay, or erroneous action or inaction by an employee or agent of SSA/CMS or another Federal Government instrumentality, the enrollment or premium rights would be impaired unless relief is given.

Policy – What does not justify relief

Relief cannot be provided under this amendment merely because of hardship or because of "good cause" for failure to enroll. There must be some erroneous action or inaction by the Government which is prejudicial to the rights of the individual.

Social Security POMS HI 00805.175 – Evidence of Government Error or Delay

Policy – Substantiation of alleged errors

The individual may allege that his/her rights were prejudiced due to misinformation received. Such allegations must be substantiated.

Policy – Required documentation

Equitable relief may not be granted unless the file contains documentary evidence. The evidence can be in the form of statements from employees, agents, or persons in authority that the alleged misinformation, misadvice, misrepresentation, inaction, or erroneous action actually occurred.

In the absence of such personal knowledge, the evidence can consist of a statement that there is a strong likelihood based on personal knowledge or prior experience that an error occurred.

Findings of Fact

1. On July 22, 2012, the Appellant turned 65 years old.

2. On July 27, 2012, the Appellant applied for Medicare Part A. The Appellant at that time did not want to enroll in Medicare Part B (Exh. 1, p. 47).

3. On May 13, 2013, the Social Security Administration (SSA) advised the Appellant that he was entitled to Medicare Part A beginning July 2012 and Part B beginning July 2013, and that his Medicare Part B monthly premium was $104.90 beginning July 2013 (Exh. 1, pp. 42–43).

4. On January 2, 2014, the SSA advised the Appellant he had not timely paid the Medicare premium amount of $99.60 for Part B insurance and that as a result the Appellant's last month of Part B coverage was December 2013 (Exh. 1, pp. 40–41).

5. On January 3, 2014, the SSA advised the Appellant that his Part B coverage would start July 2013 and his monthly Part B premium was $104.90 (Exh. 1, p. 38–39).

6. On November 28, 2016, the Appellant received a $667.40 bill from SSA, including $265.40 for Part B premiums for the period of October to December 2016, $402.00 for

date of the Appellant's entitlement for hospital and medical insurance under Medicare to July 2012 (Exh. 1, pp. 17–19).

15. On August 3, 2017, the Appellant filed a Request for Equitable Relief. The Appellant stated that he had no notice that he had Part B coverage from January 2017 to August 2017, thus he did not use his Medicare coverage. The Appellant stated it "seemed unfair that [he] be billed for premiums when [he] had strong reason to believe that [his] coverage ended." The Appellant requested (1) equitable relief; (2) that his Medicare Part B coverage be withdrawn from January 2017 to June 2017; and (3) that he be re-enrolled in Part B starting July 2017. The Appellant also attached a "Compromise Proposal for Medicare" to his Request for Equitable Relief. The Compromise Proposal stated: "(a) I accept that I have had no coverage from January 1, 2017 through June 30, 2017. So I pay no Medicare premiums for those months. (b) My Medicare coverage is reinstated as of July 1, 2017. The $450 I paid in the first half of 2017 is not refunded; instead it is applied to the premiums due from the beginning of July and going forward. So I am not at risk of incurring a penalty on my future Medicare payments as a result of the mutual misunderstandings occurring in the first six months of this year." (Exh. 4, pp. 65–68).

16. On August 14, 2017, the SSA notified the Appellant that the next retirement benefit check he would receive would be for $790.40 which was the money he was due through August 2017. The SSA noted that it was deducting past-due premiums from the retirement benefit check. The SSA also noted that the Appellant would then receive $1045.00 after August 2017. The SSA also stated that the Appellant was entitled to medical insurance beginning July 2013 (Exh. 1, pp. 14–16).

17. On September 18, 2017, the SSA notified the Appellant that it would be receiving a check in the amount of $643.60 as a refund for excess premiums for medical insurance. SSA also stated the next check the Appellant received would be in the amount of $643.60, which was the amount due through August 2017. The Appellant would also receive a payment of $1045.00 for September 2017 on or about the fourth Wednesday of October 2017. The SSA also noted that the date of entitlement for medical insurance was changed to July 2017 "as you requested" (Exh. 1, pp. 11–13).

18. On October 29, 2017, the SSA notified the Appellant that (1) the Appellant's Medicare part B start date was corrected to July 2017; (2) the SSA refunded $643.60 due for excess premiums withheld. The SSA then explained how it arrived at the refund amount. On January 10, 2017, SSA sent a letter stating the Appellant had Part B coverage from July 2013, which meant the Appellant had continuous and active Part B coverage back to July 2013. SSA stated "due to the vague wording of that letter and no other statements about the coverage being reinstated, it's understandable that you were still unsure about your part B being active at that time." Thus, SSA resumed billing of premiums because the Appellant's coverage was active. The Appellant only made one payment of $100.00 on March 24, 2017. Then, on March 31, 2017, SSA stopped the Appellant's Part B coverage because he had not paid enough towards his premiums. Then, in August 2017, the Appellant requested relief for Part B and the SSA reinstated his original coverage back to July 2013 which meant he owed premiums from January 2017 to July 2017. From January 2017 to July 2017, the Beneficiary had only paid $100.00 towards his Part B premiums. Thus, the SSA withheld the Appellant's monthly benefit check. However,

for payment of all premiums that had not been paid during that time period. The SSA also notified the Appellant that even though he did not have Part B coverage, he was still liable for the outstanding amount of $485.40 which would be deducted from his monthly benefit payment scheduled for August 2017.

On August 3, 2017, the Appellant requested equitable relief. On August 14, 2017, SSA reinstated the Appellant's Part B entitlement date to July 2013. The Appellant requested the entitlement date be changed to July 2017 because he would be liable for payment of all premiums that had not been paid if the entitlement date was July 2013. On September 18, 2017, SSA changed the Appellant's Part B stop date to December 31, 2016, and entitlement date to July 2017, as the Appellant had requested. On October 29, 2017, SSA stated that due to the vague wording of its January 10, 2017 letter it was possible that the Appellant would not have known that his Part B coverage had been reinstated and that he had continuous, active coverage since July 2013. SSA then refunded the Appellant $643.60 for excess premiums withheld.

On February 5, 2018, SSA issued a Notice of Reconsideration which stated the Appellant had a stop date of December 31, 2016, and a new entitlement date of July 2017 for Part B coverage. This means that the Appellant did not owe monthly premiums from January 2017 to July 2017. Moreover, because of this change in Part B entitlement to July 2017, SSA refunded the Appellant for any excess premiums that it withheld from the Appellant's SSA monthly benefits. Therefore, SSA does not owe the Appellant any money for Part B premiums from January 2017 to July 2017.

Reimbursement for March 2017 $100 Payment is denied

The Appellant also requested a reimbursement for the $100 payment he made towards Part B premiums on March 24, 2017.

On October 29, 2017, SSA provided a breakdown of the premiums owed and paid from July 2013 through September 2017 (Exh. 1, pp. 7–8). The breakdown indicates that the Appellant did not pay in full every year leaving an arrearage or overage.

- From July 2013 to December 2013, the Appellant owed $629.40 in premiums, the Appellant paid $634.70 in remittances, which left an overage of $5.30.
- From January 2014 to December 2014, the Appellant owed $1258.80 in premiums, the Appellant paid $1088.80 in remittances, which left an arrearage of $170.00.
- From January 2015 to December 2015, the Appellant owed $1258.80 in premiums, the Appellant paid $994.10 in remittances, which left an arrearage of $264.70.
- From January 2016 to December 2016, the Appellant owed $1461.60 in premiums, the Appellant paid $1346.20 in remittances, which left an arrearage of $115.40.

SSA applied the previous years' arrearage and overage to the 2016 balance, which equaled a total of $544.80 in premiums owed for Part B services provided from July 2013 through December 2016. The Appellant has not contested the fact that he had Part B coverage from July 2013 to December 2016. The premiums owed up to December 2016 equaled $544.80. In March 2017, the Appellant submitted a payment of $100 which applied to this $544.80 balance. The Appellant still owed SSA a balance of $444.80 for Part B coverage up to December 2016. The Appellant is not entitled to a reimbursement of his $100 payment.

Order

The Medicare Contractor is DIRECTED to process the claim in accordance with this decision.

SO ORDERED

Dated: JUN 28 2019

Kevin M. McCormick
Administrative Law Judge