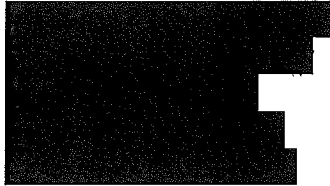
Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
phone: 401.462.2132 fax: 401.462.0458

August 12, 2015

Docket # 15-1052
Hearing Date: July 7, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided against you. During the course of the proceeding, the following issue(s) and Agency regulation(s) were the matters before the hearing:

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE (RIHBE)

SECTION 7.8 Effective Dates of Termination
SECTION 12.0 Exchange Trust Payments

The facts of your case, the Agency regulations, and the complete administrative decision made in this matter follow. Your rights to judicial review of this decision are found on the last page of this decision.

Copies of this decision have been sent to the following: You (the Appellant), your authorized representative, and Health Source RI (HSRI) Agency representatives: Noah Zimmerman, and Lindsay Lang.

Present at the hearing were: You (the Appellant), your authorized representative, and HSRI representative Noah Zimmerman.

ISSUE: Should the appellant be reimbursed for her February 2015 premium payment as she had Medicaid coverage beginning on February 1, 2015?

RIHBE RULES AND REGULATIONS:
Please see the attached APPENDIX for pertinent excerpts from the Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange

APPEAL RIGHTS:
Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:

The Health Source Rhode Island (HSRI) representative testified:

- She (the appellant) was enrolled in a Neighborhood Health Plan of RI (NHP) and Delta Dental of RI plan from January 1, 2015 through February 28, 2015.

- She went to a Navigator in mid-February and determined she was Medicaid eligible, and subsequently received a disenrollment notice on February 14, 2015 and on February 17th received an eligibility notice letting her know she was now eligible for Medicaid.

- Policy states that if a customer becomes eligible for another insurance they must inform us at least 14 days prior because the carrier has to begin their billing cycle earlier in the month.

- There is additional policy which says that when there is a change in income the customer is responsible to let us know of the change within 10 days due to tax credits, and changes in insurance such as in this case, where she is eligible for government sponsored insurance such as Medicaid.

- Because of that we would have needed to know of the change in income as soon as it happened.

- We learned about the change of income on February 13th and sent her a February 14 disenrollment notice indicating disenrollment to take place on February 28th, due to her Medicaid eligibility.

- It's our position that because she did not dis-enroll until mid-February she would carry QHP (qualified health plan) coverage until the end of the month although her Medicaid became active February 1st retroactively.

- She was carrying double coverage for that period.

- She had her notices sent by email per her request, as she chose a preference for email.

- The invoices are sent by US post office.

The appellant testified:

- On December 30, 2014 she paid $240.09 for coverage in January for a new health plan.
- She was unable to pay the Invoice dated January 5, 2015 (for February) with a payment of $204.09 due as she had no money coming in for the month of January as TDI had shut her down, and the employer could not re-employ her.
- She received a January 29th Invoice for payment (due February 23rd for March) of $480.18 which included the past amount due for January (for Feb. coverage) which she could not afford to pay, plus the current bill.
- She could not pay this as she had no money.
- On February 13th she had an appointment at the Financial office of Memorial Hospital with her representative (present at hearing) to discuss past medical bills.
- The representative informed her she was immediately qualified for Medicaid which would cover her from February 1st.
- That same day, she called HSRI saying she would not be paying for the Invoice because she did not need coverage for February as Medicaid was paying retroactive to February 1st.
- She did not need coverage for March.
- So, February 27th Invoice showed an adjustment had been made to eliminate the January payment owed, but still showed February payment to pay for March coverage.
- She called a few days later to determine why, if January payment was adjusted, why wasn't the February (for March) Invoice adjusted when she stated she would not need March coverage.
- She called again to HSRI and they confirmed yes, she had Medicaid and probably should not have been charged.
- In April she had another change of income, and signed up for insurance which was to begin on May 1st.
- At that time she found that still had a balance of $240.09 left over from the January Invoice, so that her new payment went towards the past bill, resulting in no coverage for May due to lack of complete payment.
- On May 6, she met with the Navigator again, and together contacted HSRI.

- She was told she must pay the current outstanding balance of $94.07.

- She never paid for the month of February initially, but subsequently paid for the month of February in May when they (HSRI) told her that if she paid the bill, her coverage would begin in May-which it did not.

- She cancelled all appointments for May due to lack of coverage.

- May 23rd, she paid $147.02 and received June coverage, and now pays ongoing.

- She is now satisfied from the May situation on, but continues to dispute her current payment.

- She agrees that it's no longer an outstanding bill she wants rescinded, but is requesting reimbursement for the month of February.

FINDINGS OF FACT:

- A Notice dated February 14, 201 informed the appellant she would be losing coverage on February 28th as she was no longer eligible. It further identified she must report changes affecting eligibility within 10 days of the change.

- The appellant applied for Medicaid coverage on February 13th, and obtained retroactive Medicaid coverage beginning on February 1, 2015.

- An Invoice dated April 28, 2015 showed a previous balance of $240.09.

- The appellant filed a timely appeal of the bill of $240.09 on May 6, 2015.

- The record of hearing was held open until July 14, 2015 for additional evidence.

- Additional evidence was submitted from HSRI.

CONCLUSION:

The issue to be decided is whether the appellant should be reimbursed for her February 2015 premium payment as she had Medicaid coverage beginning on February 1, 2015?

There is no dispute that the appellant submitted financial information to HSRI on February 13, 2015 which rendered her Medicaid eligible due to a decrease in her income. There is no dispute that the appellant then had dual health coverage for the remaining fifteen days of February as the Medicaid was awarded retroactively to February 1st, and she was already receiving coverage through a QHP (qualified health plan). The appellant testified that she realized on February 13, 2015 when speaking

with a Financial Office representative of a local hospital, that she was most likely eligible for Medicaid coverage as a result of financial circumstances begun in January. She applied on that same day through HSRI for Medicaid eligibility and informed the Agency she would not be paying for her February coverage as she would be receiving Medicaid coverage retroactive to February 1st. She further revealed that at the time, she had not yet paid for her February coverage although she had been billed for it. She had explained to the Agency that she did not have the money when the bill had come due. She received a January 29th Invoice for payment for February and March coverage, and received a February 27th Invoice which she opined showed an adjustment for the February payment, but not for the March payment. In April the appellant's financial circumstances changed again, and she was no longer eligible for Medicaid, and signed up for a QHP which was to have begun on May 1st. Her coverage did not begin immediately, and she determined through HSRI that a portion of her payment had been appointed towards her outstanding balance which she still owed from the January Invoice (for February coverage). The appellant did not use her coverage in May, and was told that she would receive coverage beginning in June if she agreed to pay her outstanding bill. She paid the bill at the time, and has had coverage ongoing since June 1st. The appellant disputes payment of the outstanding bill for February.

The Agency testified that the appellant was enrolled in a QHP from January 1st through February 28, 2015. She identified in mid-February that she had a change in circumstances and was found eligible for Medicaid. He further testified that the notices and policy indicate that the appellant must identify a change in circumstances within 10 days of the change, and that if a customer becomes eligible for another insurance they must inform the Agency at least 14 days prior to the end of the month in order to give the carrier time to adjust the billing cycle. He argues that because the Agency was not notified until mid-February the appellant would carry the QHP through the month regardless of the dual coverage retroactively.

Regulations specific to the RI Health Benefit Exchange (RIHBE) determine that upon a voluntary termination request submitted at least fourteen days prior to the end of the month, then coverage will terminate at the end of the month. If the enrollee is no longer qualified due to information submitted to HSRI, the coverage, unless the enrollee requests an earlier termination date-may terminate on the last day of the month following the month in which the Exchange sent the enrollee notice of an eligibility termination. In this case, the appellant contacted the Agency in February and identified that she did not want the coverage for that month or the month of March. She did not receive coverage for March as requested. The February 14 notice legally informed the appellant she would lose her QHP coverage as of February 28th which she did. The appellant had already been receiving coverage that month through a carrier since February 1st. She was already in arrears for that month, and was billed through the January notice for payment. Although the appellant initially believed she had been relieved of the balance for February and was inaccurately being charged for the month of March, she was later informed the balance showing from the January (for February coverage) Notice and ongoing were for the lack of payment in February. Policy concurs that the appellant would not have been responsible for a March payment as she had

cancelled her policy within the required 14 day period. Similarly, the appellant was responsible for an insurance which she began on February 1st and did not cancel until midmonth. Additionally, all the notices dictated that the appellant was responsible for a notification of a change in circumstances which would have changed her eligibility. The appellant, per her testimony did not identify the change but was aware in January that her financial circumstances had changed.

Regulations further identify that payments are remitted to the carriers on behalf of the applicants, that the Exchange may establish the deadline for premium payments, and that premium payments will be applied against open premium lines, beginning with the oldest outstanding premiums. The appellant was required per regulations to pay the February payment by January 23rd. Upon a lack of payment for February coverage, and receipt of that coverage, she was correctly held responsible for payment. She terminated from health coverage and obtained Medicaid coverage, but retained an ongoing balance for the February coverage. Upon reapplication, the Agency applied her coverage payment allotted for May towards the balance in arrears, thus delaying her coverage until full payment was made towards her June coverage. Per policy, the Agency was within regulations.

In summary, the appellant applied for HSRI coverage in December 2014 and submitted her payment for January. She did not pay the February coverage citing financial considerations at the time, but incurred a bill for the month. She did not submit any financial documentation as requested per the notice which may have qualified her for Medicaid at that time. In mid-February the appellant submitted financial information which qualified her for Medicaid, and which was awarded her retroactively. Her established QHP coverage remained active, and per regulations and per the notice, terminated at the end of February. Because the appellant did not request termination prior to February she was therefore unable to have the February bill rescinded. Upon reapplication for a QHP in May 2015, her initial payment was applied, per regulations, towards the bill in arrears. As a result of credible testimony, and the due process given the appellant with regards to the notices, as well as the correct application of the RIHBE regulations, this hearing officer finds that the appellant's request for relief is denied.

Karen Walsh
Appeals Officer

APPENDIX

7.8 **Effective Date of Termination.**
(a) *Voluntary terminations.*
(1) Upon a voluntary termination request submitted at least fourteen (14) days prior to the end of the month, coverage shall be terminated at the end of the month. Coverage shall be terminated at the end of the following month if the termination request is submitted less than fourteen days prior to the end of the month.
(2) The Exchange may grant a different termination date if the request is submitted at least fourteen (14) days prior to the proposed termination date.
(3) The Exchange has discretion to grant an earlier termination date, on a case-by-case basis.
(4) If the enrollee requests coverage termination due to eligibility for Medicaid, coverage will terminate the day before Medicaid coverage begins.
(b) *Involuntary terminations.*
(1) If the enrollee is no longer a qualified individual as determined upon receipt of information from the enrollee or information obtained by the Exchange, coverage will terminate on the last day of the month following the month in which the Exchange sent the enrollee notice of an eligibility redetermination. In such a case, the enrollee may request an earlier termination date, pursuant to §7.8(a) of these Regulations.
(2) If the coverage is terminated for non-payment pursuant to §7.5(c) of these Regulations.
(3) If the enrollee dies, coverage terminates on the day of the death. Premiums will be refunded by the Exchange to the estate for the remainder of the month.
(4) If the enrollee changes Qualified Health Plans, the existing Qualified Health Plan coverage terminates the day before the new coverage begins.
(5) If the Qualified Health Plan terminates or is decertified, coverage will terminate the day the Qualified Health Plan terminates or is decertified, unless the enrollee is granted an earlier termination date pursuant to §7.8(a) of these Regulations.

SECTION 12.0 EXCHANGE TRUST PAYMENTS

12.1 **Establishment of Trust.** The Exchange shall establish the Trust for the following purposes:
(a) Collecting health and dental insurance premium payments from qualified employers and qualified individuals;

(b) Remitting premium payments to QHP issuers on behalf of enrollees who participate in QHPs offered through the Exchange;
(c) Performing functions ancillary to the collection and payment of premiums to qualified health plan issuers and the receipt of payments for such products and services as may be offered through the Exchange; and
(d) Carrying out any other functions that are reasonably necessary in furtherance of the foregoing and in accordance with the establishment and maintenance of the Trust.

12.2 **Payments to the Trust.** Qualified individuals and qualified employers may remit premium payments to the Exchange to maintain participation in a QHP in accordance with all requirements under the Act and the Federal Regulations.
(a) Premium payments may be made in advance of the coverage month to which the payment applies.
(b) The monthly premium payment deadline shall be established by the Exchange.
(c) Premium payments will be applied against open premium lines in chronological order, beginning with the oldest outstanding premium payment.
(d) Payments may be received by the Trust from qualified individuals and employers for such products and services as may be offered through the Exchange.

NOTICE OF APPELLATE RIGHTS

This Final Order constitutes a final order of the Department of Human Services pursuant to RI General Laws §42-35-12. Pursuant to RI General Laws §42-35-15, a final order may be appealed to the Superior Court sitting in and for the County of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

This hearing decision constitutes a final order pursuant to RI General Laws §42-35-12. An appellant may seek judicial review to the extent it is available by law. 45 CFR 155.520 grants appellants who disagree with the decision of a State Exchange appeals entity, the ability to appeal to the U.S. Department of Health And Human Services (HHS) appeals entity within thirty (30) days of the mailing date of this decision. The act of filing an appeal with HHS does not prevent or delay the enforcement of this final order.

You can file an appeal with HHS at https://www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf or by calling 1-800-318-2596.