



Rhode Island Executive Office of Health and Human Services
Appeals Office, 57 Howard Ave., LP Building, 2nd floor, Cranston, RI 02920
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August 21, 2015

Docket # 15-602
Hearing Date: June 9, 2015



ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided **partially** in your favor. 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

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) and Health Source RI (HSRI) Agency representatives: Noah Zimmerman, and Lindsay Lang.

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

**ISSUE: Should the appellant have to pay retroactive increased premium costs for health coverage received January through March 2015?
Should the appellant have to pay an increased premium amount for health coverage beginning on April 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:

- The family originally enrolled December 24, 2015 and they received an enrollment notice on the 25th identifying their monthly bill would be \$928.46.
- We did not inform them at any point that this was actually the 2014 rate and not the 2015 rate, so they wouldn't have known that, and that we had misquoted them.
- On the March 11, 2015 a follow up enrollment notice informed them that their monthly bill would now be \$992.60 and they were then informed through conversations with the call center that they would not only be billed proactively, but retroactively we would try to recoup the previous amounts outstanding based on the 2015 rate.
- We undercharged and misquoted them for 2014, and now it looks like we're asking them to pay the 2015 price.
- We do not dispute the many phone calls and contact made to HSRI prior to March 2015 to rectify the coverage issues.
- They should owe \$992 per month, and HSRI is saying they should pay retroactively, but there is no notice which identifies that HSRI is requesting this.
- The invoice dated May 29, 2015 is erroneous, but can be used to display the January 2015 through June 2015 amounts which show retroactive amounts of \$972.90 being billed. It is unclear if this is a retroactive bill for January through March because the bills as of April were \$992.60, and the original premium was \$928.46, and these bills now show \$972.90 for each of the previous months. It appears that the Agency also adjusted an \$11,674.74 overage.
- It appears that we had a systems error, and now the Agency is requesting retroactive payment.

The appellant and his wife testified:

- They are in agreement with the assessment that they were quoted the \$928.46 price, and subsequently began being charged \$992 and change (for April), and then also have been billed additional monies for the months they were charged at

the \$928 price.

- They paid \$928.46 for January through March.
- They had been told the price would increase to \$992, but their previous medical bills had not yet been paid because the providers could not get the claims through.
- At that time (March), a representative had spoken with her husband and he had been told that in order to get the account activated with Blue Cross/Blue Shield so that providers could be making their claims, they would have to agree to this new higher price.
- By this time, this was becoming basically an emergency situation for them with their providers so they felt they had no choice but to make that higher payment in order to get their account active, so they began paying the \$992.60 for April (in March).
- Immediately upon paying the \$992, the billing provider issues were resolved.
- Up to that point providers did not want to give them any care, because they (providers) couldn't submit their bills beginning on January 1. Providers went on faith and provided services, because the family did not show in the system, but they believed the appellant's when they told them they did have coverage. From their perspective, it felt like extortion.
- Prior to this, they had no assurance other than verbal from HSRI that they actually did have coverage all those months spent trying to get activated with Blue Cross/Blue Shield, they really could not know at that point if it was ever going to be resolved, and if all those bills piling up from their providers were going to be validated in any way.
- There was an extreme amount of stress, and they didn't know even if they agreed to pay the new amount going forward, that they would be discoverable in the system.
- They had countless phone calls and follow ups with the medical community and they asked providers to bear with them, and told them they (appellants) were working with HSRI and with Blue Cross/Blue Shield to be added to the system.
- She (appellant's wife) has dates and times of phone calls and notes of contact with HSRI (**displayed multiple sheets of information-not entered into evidence) and was given many differing responses, i.e. trying to explain what was happening, telling her it was resolved, telling her someone would call her back, telling her it was escalated, telling her a Priority team was working on it, telling her it's a glitch-and finally they were told in March that they would have to pay

more.

- We agree that the first time we paid the higher amount was for the month of April.
- In March when we were informed of the price increase, and told we were misquoted.
- A representative did mention that we could refuse coverage, and we weren't obligated to buy coverage going forward.
- They also told us that it could be considered grounds to not having health coverage, but in reality, we already had the provider bills, and the difficulties with our current payments, we felt we could not take on a separate enrollment.
- The unknown and variables and the risk was too high, so we didn't even feel that we had an option at that point.
- I would not accept any rate hike.
- We would like to explore the possibility of changing to a private insurance coverage policy as we don't feel we have benefited from HSRI.

SUMMARY of the recording between the HSRI customer representative and the appellant on February 6, 2015:

- The appellant contacts HSRI to discuss difficulties with his enrollment. He and the representative discuss his first two payments of \$928.46, and the representative expresses difficulties in accessing his home page information. The representative identifies that she had noted a payment request for \$992.60 which the appellant agrees he had seen, but offers that his bills and subsequent payments were for the agreed upon premium amounts of \$928.46, of which he has made two at this time (for Jan./and Feb. coverage). The appellant offers that he now has his cards following submission of the correct social security information, submission of the baby's birth certificate, and correction of a late payment due to his confusion about the recurring electronic option. He asks if the Agency could just take his money and then not cover him for a plan, and the representative says, No, it's not that the plan will not work, but that it appears to be a minor issue. The representative informs the appellant he is active in insurance as of January 1st, as he made the payment. She recommends he contact Blue Cross, and "make sure they have you confirmed" and that you are making payments. She verbalizes, that if Blue Cross says you are not covered, "call us, so we can do an emergency act for you" in order to cover doctor appointments and prescriptions. The appellant asks if the payments made are proof that he has had coverage the whole time. The representative agrees, yes, that is proof. The appellant confirms that "if they (we) make a claim and Blue Cross says (we're) not signed up, then it"...gets sorted out at a later time. The

representative recommends he continue payments. The appellant agrees to allow the escalation team to deal with the incorrect paperwork at that time.

SUMMARY of the recording between the HSRI customer representative and the appellant on March 5, 2015:

- The customer service representative contacted the appellant on this day. The appellant indicates he received a call from Blue Cross, and "it" is fine. The representative indicates that the rates quoted at the time of enrollment were incorrect. She allows the option to pick another plan at or around the same price, or remain at the 2015 rates, which she quotes. The appellant agrees to keep the current plan, and he is informed he must choose some option immediately. The representative indicates he and his spouse can make a change in the choice after reviewing the options and plans, and an agreement is made to discuss the choice over the weekend.

SUMMARY of the recording between the HSRI customer representative and the appellant on March 8, 2015:

- The appellant identifies that he and his wife have spoken about "it" and they have chosen to remain with the current coverage choice at the higher rate-"that's fine." He identifies he is aware of the new price-\$992.60 per month, and states that they agree to stay with the same plan at this new 2015 rate. The representative identifies the starting date is January 1.

SUMMARY of the recording between the HSRI customer representative and the appellant's spouse on, or around March 15, 2015:

- The appellant's wife informs the representative that her husband was told in a previous phone call, that in order to make the account active, HSRI was raising the premium, and she identified that the family would not accept a rate hike. She reiterates the difficulties with her account, and reports her frustration and her anger. She relates that she can just now access her account (begun on January 1st) and providers can now submit claims. The spouse reiterates that they have just gotten this resolved after "hours and hours of prodding" HSRI. She establishes that her husband made a decision to agree to pay a higher rate for April because in part he did not know what else to do, and she feels that her arm was being "twisted" at the time. She asks if the family is "committed" to that decision. The representative identifies that the appellant has an option to appeal the first three months of retroactive billing, and she recommends that this should be honored, as the "customer is always right", and they were not informed prior of the misquote. She discusses additional options which include remaining with the current plan at the 2015 rate beginning in April, choosing a different carrier or plan at the 2015 rate, or choosing to leave HSRI for a private plan. The representative and the spouse repeat the options several times. The appellant's wife repeats her understanding of the appeal to address the months of January

through March regarding the retroactive billing; she repeats her understanding of the choice to leave HSRI for a private plan, and states her concerns about committing previously (concern about open enrollment, special enrollment, non-acceptance for coverage); and, she repeats her understanding about choosing a new plan or staying in the current plan at the new 2015 rates. The wife chooses not to look at other plans at that time. With regards to choosing to stay in the current plan, she asks, if the new plan would begin April 1 at the new rate; and, if that rate is considered "separate from anything that happened January through March". The appellant's wife and the representative are unable to continue the call, and they agree to speak the following day. With regards to the future call, the representative states, "you're going to file the appeal moving forward..." and we are going to go over whether you're going to keep this plan, or go over a new health plan, or if you're going to dis-enroll." She adds that this will allow the family to discuss the issue, file the appeal, and make an executive decision about what to do moving forward.

FINDINGS OF FACT:

- A December 25, 2015 enrollment notice informed the appellant that effective January 1, 2015 he was eligible for health coverage at a cost of \$928.46 per month.
- During a March 6, 2015 call between a HSRI customer representative and the appellant, the appellant was informed that HSRI had mistakenly quoted the 2014 coverage prices, and that there would be a resulting price increase.
- A March 11, 2015 enrollment notice informed the appellant that he was eligible for health coverage beginning on April 1, 2015 at a cost of \$992.60 per month.
- The appellant filed a timely appeal on March 11, 2015.
- A Full Payment History read out showed that the appellant had paid \$928.46 for the months of January through March 2015; and, \$992.60 for the months of April and May 2015.
- An Invoice dated May 29, 2015 indicated a retroactive billing amount for \$972.90 for the previous months of January through June 2015.
- A hearing was held on June 9, 2015.
- The record of hearing was reopened on June 12th for additional evidence in order to fully develop the record-additional evidence was received.
- The appellant requested a held open extension to July 17th and then again until July 24, 2015 in order to receive the evidence and to respond if desired.

- Additional evidence was received.

CONCLUSION:

ISSUE: The two issues to be decided are- Whether the appellant should have to pay retroactive increased premium costs for medical insurance received January through March 2015; and, whether the appellant should have to pay an increased premium amount for medical insurance beginning on April 1, 2015.

There is no dispute that the appellant was incorrectly assessed by HSRI for premiums effective January 1, 2015. The Agency identifies that the initial quotes were based upon 2014 Federal Poverty Level, rather than the 2015 numbers, and that the appellant was not aware of this rate initially. There is no dispute that a December 2014 notice identified that the premium amount was \$928.46, the amount agreed upon by the appellant. A subsequent notice dated March 11, 2015 indicated the new premium amount as \$992.60 to become effective on April 1, 2015. There is no dispute that the appellant paid the initial amount from January 1 through March 31, 2015, and began paying the higher amount as of April 1st. There is no dispute as well, that the family did not receive APTC's (advanced premium tax credits).

The appellant argues three different issues relating to increased premiums. The first is a consideration of retroactive payments billed by HSRI.

The Agency testified that the appellant and his wife enrolled for 2015 health coverage in late December 2014. They were informed that beginning on January 1st they would have coverage which would cost \$928.46. On March 11th a subsequent notice informed them that their new premium amount would be \$992.60 effective April 1, 2015. In March, they were also informed by HSRI (Health Source RI) that they would be responsible for retroactive payments, although the Agency noted no corresponding notices which indicated this action. The Agency testified that an Invoice dated May 29th may have suggested an attempt by the Agency to adjust for the initial deficit, as it showed the amounts of \$972.90 being retroactively considered for the months of January through June 2015. He further testified he was unclear what his Agency was requesting, as they had not identified in a notice what they were requesting, and the bills and invoices submitted into evidence were unclear.

Regarding this first issue, the appellant testified that they had difficulties ongoing with HSRI and although they had understood coverage from January 1st on, they had ongoing negotiations with HSRI to insure they had coverage, as both Health Source and their providers could not find them in the "system" up to sometime in March. They testified to "prodding" HSRI for resolution. They presented that they asked providers "to bear with them" and to allow them continued appointments and medical intervention, despite the lack of evidence that they had any coverage. The providers allowed ongoing

services. The appellant and his wife gave credible testimony relating their frustration, stress, anger, and time spent attempting to rectify the omissions. They testified that sometime in late February or early March they became aware that they had been incorrectly assessed for premium amounts, and that beginning in April they would be assessed for an additional \$64.14 per month. Subsequently, they were informed that the Agency would be retroactively assessing them for additional monies for the initial three months in which they received coverage at a reduced rate. The appellant argues that they should not be responsible for these payments as they had agreed upon a price, had used the services, and had paid for the services, although they were not clear until March that providers would actually receive payment.

Due process requires at the minimum, an announcement of what and when something will happen. In this case, the appellant obtained and paid for services from January through March 2015 at an agreed upon price, and a price cited in the December notice. Post payment and post receipt of services the Agency appears to have billed the appellant for a retroactive amount in order to "recoup" the discrepancy which would have totaled \$64.14 per month if the subsequent April premium amount quoted was correct. At no time, did the appellant receive, in writing, an explanation of what the Agency was intending to do either prior to or retroactively. For this reason, the appellant will not be liable for any retroactive payments billed for the months of January through March.

The second issue in dispute is whether or not the appellant should have to pay a higher premium beginning April 1st. The Agency argues that a notice sent out on March 11th, and prior conversations with HSRI, informed the appellant that as of the beginning of the next month, April 1, they would incur a higher premium. They further argued that the Federal Poverty Level for 2014 changed in 2015 and this was not initially taken into consideration when assessing the appellant in December 2014. They admit their mistake and testified to the increased premium cited in March as a correction of that mistake. The appellant argues that they had been told in December of 2014 that the premium was one amount, and they expected that amount to be locked in and remain the same ongoing.

The appellant was given timely and correct notice in March allowing time to change plans, or to accept the higher premium. In the case of a change of circumstances for the appellant during the year, or a misrepresentation, the premium must be corrected. Similarly, the Agency rectified their initial mistake by charging the correct amount with due notice, to the appellant. The appellant received the benefit of a less expensive premium for three months, and had ample time to change carriers, or plans, or to leave HSRI altogether. They chose to pay the higher premium and remain with HSRI. Thus, the appellant would be responsible for a higher premium beginning on April 1, 2015.

The third issue in contention, is the appellant's argument that he should not be held responsible for the higher premium as he did not feel he had any other options. He testified that he believed that he was coerced into accepting the higher premium and thus was forced to remain with HSRI. In essence, he did not have a choice. The

appellant, as previously discussed, indicated that the family medical bills had not been paid by their carrier as late as March 2015. When faced with the possibility of accepting an increased premium for April 1st he and his wife were fearful of a separate enrollment for numerous reasons (also discussed prior). The appellant's wife testified that "it felt like extortion".

Post hearing, several recorded conversations between the Health Source RI customer representatives and the appellant and his wife were submitted into evidence.

During the February 6, 2015 taped conversation with the appellant the customer representative notes some glitches in the system, but identifies the appellant has coverage and proof of coverage, and payment as of January 1st. She asks the appellant to clarify with Blue Cross whether or not they show coverage, and requests a call back if there are issues. The appellant identifies that he has his medical cards and notes as well, that he has inadvertently paid the payment for February late due to some difficulties in signing up for the online recurring payment.

The March 5th call between the appellant and the representative reveals that HSRI has mistakenly quoted the 2014 rates at the time of enrollment, and that the appellant can choose to pick a new plan at about the same rate, or pay the higher premium rates beginning on April 1st. The representative asks the appellant to choose some option immediately for the application purposes, but allows the family to consider the options and call in during the weekend to change the plan. She states that the family is "still active in Blue Cross..." With regards to coverage, the appellant indicates that he received a call from Blue Cross on March 4th, and that "it is fine."

The weekend call on March 8th takes place between the appellant and the representative. During this call, the appellant states that he and his wife have discussed the issue, and they will remain with the same plan at a higher premium. The representative ends the call indicating the starting date of January 1st.

According to a March 15th taped conversation between a HSRI customer representative and the appellant's wife, she voiced her fears of lack of coverage to the representative (discussed previously). She identified that her husband had chosen to continue coverage with the same carrier at the increased price, and agreed to retroactive January 1 increased premiums as a result of this pressure. The appellant's wife disputes his choice stating that he did not know what to do at the time, and the feeling was that her arm was being twisted. Further exploration of the tape reveals that the appellant's wife, as of the time of this recording, identifies that she had just been able to access her account, was able to have providers submit claims, and verbalized that her other systems issues have been resolved. The representative submits three solutions for the appellant moving forward. First, she offers, and recommends that the appellant appeal the issue of retroactive payments for the first three months. Second, she offered that the appellant could continue coverage with the same carrier and different plan, or a different carrier-all would be at the 2015 price. Third, the representative informs the spouse that she can leave HSRI for a private plan with no sanctions. The

representative agrees to allow the appellant time to consider the options, speak with her husband, and make a decision about moving forward. It is agreed that they will speak the following day. During the conversation, the appellant's wife reiterates the three suggestions. Regarding the choice of staying with the current plan, she asks again about the starting date of the new plan as being April 1, and at the new 2015 rate. Regarding the increased premium, the spouse clarifies that this rate would be considered "separate from anything that happened January through March." The representative repeats, "You're going to file the appeal moving forward."

Thus, although the appellant and his wife gave credible and undisputed testimony as to their emotional state throughout the process, this final reconciliation in mid-March does not support the appellant's contention that he and his wife were being pressured or coerced by the Agency to sign up for April or else the previous bills would not be paid. As of the timing of this call, the issue of discoverability and subsequent resubmission of bills had been rectified. The representative clearly indicated the appellant should file an appeal for the first three retroactive months, and that he would most likely win such an appeal due to his lack of fault. The representative clearly indicated to the appellant and his spouse that they could leave HSRI at this time, and she further supported the appellant in doing so, identifying reasons that would allow the husband and wife to sign up without sanctions with private insurers. Last, the evidence does not support the couples argument that they felt they must sign up for April, as the appellant's wife clarified with the representative that the new rate moving forward was "separate from anything that happened January through March."

In summary, in December 2014 the appellant applied for medical insurance for 2015 through HSRI. He was quoted the 2014 premium prices which were lower than the actual 2015 prices. The appellant paid medical premiums from January 1, 2015 through March 2015 at the lower prices. In early March 2015 the appellant was properly notified both verbally and through notice that the premium price would be \$64.14 higher per month, beginning on April 1, 2015. He was also verbally notified that he would be responsible for retroactive payments for the months of January through March. This may have been reflected in a confusing billing Invoice dated May 29, 2015, but the Agency and the appellant were unable to read the bill due to the numerous inconsistencies. Regardless, notice was never properly given for retroactive consideration so he will not be held responsible for any retroactive adjustments to his January, February and March premiums which he had paid in full.

The appellant and his wife gave credible and undisputed testimony that the process of obtaining coverage through HSRI and the ensuing and ongoing problems created feelings of distress, anger, and at one point, a sense of coercion and extortion. Despite the unfortunate experiences expressed by the appellant, the evidence submitted post hearing clarifies that the appellant was not coerced into remaining in the same plan at a higher rate. He was given due notice of the increase in premiums, and was verbally informed on March 5th, March 8th, and on March 15th, that he still had several options available. The appellant was allowed the choice to continue coverage during the month of April at the 2015 rate; was allowed the choice of choosing a different plan/and or

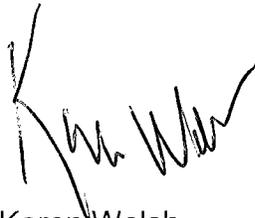
carrier at or around the initially quoted premium price; and, was allowed the option of leaving HSRI and choosing a private carrier. The appellant was made aware that these options were apart from considerations related to the January through March issues. Additionally, the appellant's inadvertent late payment for February may have caused some of the initial "glitches" in the system with regards to the appellant's lack of "discoverability" in the system.

After a careful review of the Agency's regulations, as well as the credible testimony given, the Appeals Officer finds that the appellant's request for relief is therefore **granted** in that he will not have to pay any increased retroactive premium amounts assigned to his account for the months of January through March 2015.

A proper and legal enrollment notice was generated on March 11, 2015 which indicated an increase of premiums to take place 20 days forward beginning on April 1, 2015. This hearing officer did not find that the appellant had been coerced into accepting the increased premiums, but was given several choices for insurance coverage. Thus, with regards to the second issue, the appellant's request for relief is **denied** in that the appellant is responsible for the increased premiums, as cited in the March notice, beginning on April 1, 2015.

ACTION FOR THE AGENCY:

HSRI is to insure that retroactive bills for any premiums for the three months noted are rescinded. HSRI is to allow waiving of the 14 day notification of termination if the appellant identifies in August 2015 that he would like to voluntarily terminate his coverage prior to September 1st. In the event the appellant withdraws from coverage after August the applicable regulations for termination time frames will apply.



Karen Walsh
Appeals Officer

APPENDIX

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE

7.0 TERMINATION OF COVERAGE AND GRACE PERIODS

7.8 Effective Dates of Termination

(a) Voluntary terminations

1) 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.

2) 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.

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.