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

February 10, 2015

Docket # 14-1869
Hearing Date: January 13, 2015

[redacted]

ADMINISTRATIVE HEARING DECISION

The Administrative Hearing that you requested has been decided 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 Agency representative Noah Zimmerman.

ISSUE: Does the appellant owe outstanding bills for medical coverage for any months from July 1, 2014 through January, 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 Agency representative testified:

- We (HSRI) are aware of the two issues-the first being the bill for July 2014, and the other issue being the ongoing billing he has been receiving despite it (coverage) being terminated for July.

- The last time we met, our office told him we would be asking Blue Cross to waive the cancellation rule and to retroactively dis-enroll him back to June 30, 2014.

- Obviously we would deal with the bills which keep being added to his account despite his disenrollment.

- If the carrier allows him to retroactively dis-enrolled back to June 30th, he would not have to pay the July bill, and this would resolve the issue.

- As of this time, we are waiting to hear from Blue Cross as to whether they will allow this.

- HSRI is trying to advocate for him (the appellant), but they understand this is not in the policy, it is an advocacy issue.

- Policy indicates that termination of coverage would necessitate that the enrollee notify at least 14 days prior to end of the month, or he would owe for the following month.

- In his case he called HSRI and terminated on the first day of July, which would mean per policy that he would be terminated from coverage on the last day of the month in which he requested cancellation.

- If we went strictly by policy-if he (the appellant) called any time in July, he would owe for that month.

- The second issue is the increased bills he has been receiving after July, and we understand that these bills should not have been incurred, and we are working on that now.

- These should not show in his next bill.

- The Agency notes indicate that the appellant did call HSRI in June. He did call and he said he was going to dis-enroll but wanted to look into it first. HSRI cannot confirm the date or the content of the call.

The appellant testified:

- He wants to avoid paying $480.00 for the month of July.
- The office (HSRI) has records that he has paid the whole month of June.
- He began calling HSRI in June because he was being transferred to another side at work, and was not sure how this would affect the cost of his insurance; so, he was calling to find out what he would have to do to if he did cancel his policy.
- He did not ask them to cancel his policy at that time.
- They told him that he just needed to call them (HSRI) and cancel, but did not give him any information about the 14 days prior to cancellation, which he heard for the first time at hearing.
- They had told him that if he wanted to cancel at that minute, he had nothing else to do as he was "all set" and was "all paid off" for the month of June.
- He thought he called them two times in June for information.
- His first call to them was on the 18th of June.
- He called back on July 1st on the day he enrolled in the other company, and he cancelled on that day because he switched over.
- When he got the notice in July that he was dis-enrolled he thought it was all done.
- In August, he got a bill that said he owed them for July and August, $480 for each month.
- He used to get a bill around the 12th or the 15th, and he went straight into the office and paid directly on the 18th.
- The last bill is now up to $2884.08 on the bill dated 1.5.15. The due date is the 23rd of January.
- He doesn't recall ever seeing that cancellations would need to take place 14 days prior to closing.

- At least once a month he calls them to ask about the continuing bill.

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FINDINGS OF FACT:

- A notice dated July 2, 2014 informed the appellant that all of his household members would lose coverage on July 31, 2014 as they "got other coverage."
- Timeliness considerations were granted at hearing on the appeal filed by the appellant on September 23, 2014.
- A hearing was held on January 13, 2015.
- The record of hearing was held open until February 3, 2015 for additional evidence.
- No additional evidence was submitted prior to the close of hearing.

CONCLUSION:

The issue to be decided is whether the appellant owes outstanding bills for medical coverage for any months from July 1, 2014 through January, 2015.

The appellant argues that he should not be eligible for payment for the month of July specifically, as he was unaware of policy around the issue of 14 day prior notice, and he contacted the Agency before closure for instructions. He further argues that he should not be responsible for the continued accrued bills from August 2014 on as he had received a notice indicating closure on July 31, 2014. He did not receive a bill for July after his closure, until August when he received the combined bills for July and August.

Regulations specific to the RI Health Benefit Exchange (RIHBE) identify that a request for termination of coverage must be submitted at least fourteen days prior to the end of the month. Policy further notes that coverage shall be terminated at the end of the following month if the request is submitted less than fourteen days prior to the end of the month.

There is no dispute that the appellant should not be responsible for the ongoing bills accrued from August 1st on. The HSRI representative agreed that the notice dated July 2, 2014 indicated that all household members would be losing coverage on July 31st. Thus the notice itself supports the appellant's complaint that he should not be charged for ongoing months, as the coverage had ended, and the Agency was aware at least 29 days prior to August 1st, that the coverage would be ending. The representative agreed that this mistake should be rectified. With regards to the second issue of the initial

termination dates, there is no dispute that the appellant asked for closure of his policy on the first or the second day of July. According to RIHBE regulations this would make him responsible for the July coverage.

The appellant argues that he contacted Health Source Rhode Island (HSRI) in June on one or two occasions. He informed the representative that he would most likely be dis-enrolling but wanted to know the process. He testified that at the time, the representative informed him that he needed to do nothing but let the Agency know of the closure. He further testified that he was informed that if he "wanted to cancel at that minute, he had nothing else to do as he was all set and was all paid off". He stated the representative was speaking of his June payment which he had made in May. The appellant reported that at no time was he informed of a 14 day period within which he must cancel. Additionally, he did not become aware of the deadline until he appeared at hearing. He further testified that he contacted the Agency on June 18th, but also thought he had spoken to them twice in June. The appellant then contacted HSRI to cancel his policy officially on July first or second.

The record of hearing was held open for three weeks, but no additional evidence was submitted. The Agency representative did not dispute the calls to HSRI in June, and was unable to confirm the content or the dates of the calls. If the appellant had made his first call to HSRI on June 18th, he would already have incurred the July bill of $480 as he did not have fourteen days left in the month for notification, and the representative would have been expected to inform the appellant of this. However, at first contact with HSRI, the representative was either willing to waive the 14 day notice (as he had only 12 days left instead of 14), and told the appellant he was all set and had to do nothing else, or she was aware that he still had time left on the clock within which to cancel (because he had called prior to the 16th). If that is the case, there was no explanation by the Agency as to why the representative did not inform the appellant of the fourteen day cancellation policy, when the appellant specifically contacted the Agency to determine the cancellation policy. If the representative was allowing the appellant to terminate at that moment she would have had to inform the appellant he would need to cancel immediately. At hearing, the Agency testified that they were aware only that the appellant had called and discussed cancellation, but did not cancel. The Agency did not dispute testimony that the appellant was told he was "all set" at the time, and further did not dispute that he had **not** been told by HSRI about the fourteen day cancellation policy.

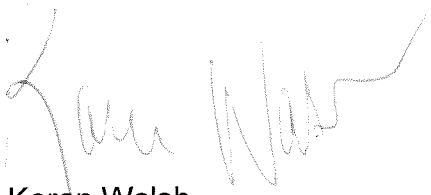
The Agency further agreed that they had been attempting to advocate for the appellant in this matter, but in the event this was not successful, their specific policy required that he pay for the month of July.

In summary, policy cites that an enrollee must submit a request for termination of medical insurance at least 14 days prior in order to obtain termination in that month. Per policy then, the bills incurred from August on were incorrectly assessed and the appellant is not responsible for these. With regards to the July bill, the appellant's ignorance of policy does not absolve him of his responsibilities as an informed

consumer to know the rules and regulations, or at least to request clarity. The appellant gave credible and undisputed testimony that he contacted the Agency in June to determine just that. He testified that he had called HSRI for an understanding of how he should go about terminating his coverage, and whether or not it would be in his best interest do so. He was calling specifically for closure information, as he had no other issues at that time. He was not informed that he must contact the Agency at least fourteen days prior to termination, and in fact was told he was all set, or could call at any time, and cancel the policy. As a result of the omission of information and/or wrong information, the appellant called on the first day of July, and requested cancellation. He thought he had successfully terminated, as he did not receive a bill for July which should have arrived in mid-June. Upon receipt of two bills in August he realized he was still being billed. The bill continued to accrue at least up to the time of hearing. As a result of the omission of closure information specifically requested by the appellant from HSRI, the appellant did not close his case in a timely manner. Consequently, this hearing officer finds that the appellant made a decision about termination dates, and incurred a bill for July 2014 as a direct result of the lack of information and/or poor information received from HSRI-although he made a good faith effort to obtain direction prior to closure. Therefore, the appellant is not responsible for any of the bills incurred from July 1, 2014 and later.

After a careful review of the Agency's regulations, as well as the credible and undisputed testimony given, the Appeals Officer finds that the appellant's request for relief is therefore granted.

ACTION FOR THE AGECNY:
HSRI is to insure that the bill for July 2014 and all subsequent bills accrued after that date-are rescinded.



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 termination

i) *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.

ii) *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.