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 26, 2015

Docket # 14-1923
Hearing Date: January 20, 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
SECTION 5.5 Calculation of Advance Payments of the Premium Tax Credit
SECTION 5.0 Advanced Payments of the Premium Tax Credit

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: Is the appellant responsible for any health coverage premiums and/or tax penalties incurred for the month of September 2014?

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:

- Based upon what the appellant is telling me today, she had tried to dis-enroll via phone and that happened early on in August (2014).
- Unfortunately we don't have anything in my system which corroborates this at this time, but I could explore this.
- We do have a dis-enrollment notice of Sept.4 (2014) which is being disputed today.
- Our termination policy is that in case of a termination where the enrollee wishes to terminate coverage, the last day of coverage will be the last day of the month during which termination is requested by the enrollee so long as it is requested at least 14 days prior to the end of the month.
- From the information provided today, I believe she did request dis-enrollment at least 14 days prior to the end of the month
- As to my understanding of the facts currently, I believe she should not have had to pay for September coverage, but I'll need to do some investigation to confirm this.
- It would be my understanding and preference to go to the carrier, and see if they would cancel your coverage for September so that you would not be billed for September.
- It appears that she is still receiving a bill after September but there are no new charges, just a continuing bill of $169.00.
- We are not disputing her (the appellant) account of the HSRI phone procedures.
- The invoice dated July 25th, showed the increase to $345.68, which was due on August 23rd for September.

The appellant testified:

- She had mailed in a correspondence on August 6th stating that she wanted to cancel effective September 1st.
- She had tried to call (HSRI) prior to writing the August 6th (2014) note, and stayed on the phone for hours and hours, and when her batteries died she had to hang up.
- She called a second time, and she was put on hold, and one cannot leave a message, and she did not.
- She wrote the cancellation note in the box on the portion of the bill which is sent in with the check.
- The main reason was that the bill had more than doubled and also she was going to be eligible for Medicare beginning on September 1st.
- She had been under the assumption that she had already cancelled her policy, but then got the September 4 (2014) notice.
- She also received the next bill around September 3rd, and again she tried calling (HSRI), and this time she reached someone and explained the story to the person.
- The person she spoke to claimed that the only way you could cancel a policy was verbally, and you cannot do it by mail.
- She asked to speak with a supervisor who she spoke to, and who also confirmed that that was the case.
- The representative did not know where the correspondence was or if it had even gotten there.
- She explained it had to have gotten there because they did receive the check that was with it, which was $28.89 for dental coverage only.
- She was very upset, and asked if they could please insure that it was cancelled immediately, because she could not afford it.
- She then appealed the issue.
- She also kept notes from July 2, 2014 through September 14, 2014.
- On July 3, 2014, she paid $140.48 premium by phone for the August premium.

- This was the usual premium prior to the change for September.

- She never paid the bill for September ($345.68) as she had already paid the August premium in July.

- She paid the dental of $28.89 for September, and thinks she last used the dental in September.

- She had wanted to continue with only dental coverage through October, but she was accidentally closed to dental in October when they finally cancelled the health insurance.

FINDINGS OF FACT:

- A notice dated September 4, 2014 informed the appellant that her Blue Cross/Blue Shield health coverage would end on September 30, 2014.

- A check for dental coverage only, and a note requesting cancellation of the health insurance policy was sent to HSRI by the appellant on August 6, 2014. The check was subsequently cashed.

- The appellant was informed by HSRI on September 3rd that the policy could only be cancelled verbally.

- The appellant filed a timely appeal on September 30, 2014.

- A hearing was held on January 20, 2015.

- The record of hearing was held open until February 10, 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 is responsible for any health coverage premiums and/or tax penalties incurred for the month of September 2014?

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.

The appellant testified that she decided to cancel her health insurance policy because it was doubling in price as of September 2014, and because she would be receiving coverage through Medicare on September 1st. She further testified that she attempted to contact HSRI by phone sometime in early August 2014 in order to cancel her September premium. She stated that she remained on the phone for hours on one call until her battery died; and, tried a second time to contact the Agency where she remained on hold for a lengthy period and was unable to leave a message. The Agency did not dispute that this was most likely the procedure, but no documented evidence could substantiate attempted calls. The appellant testified she then sent in a payment of $28.89 on August 6th for her dental coverage only, which was cashed by the Agency. She identified that her usual payment was $140.48 which she last paid on July 3rd for her full medical coverage to continue in August. The appellant reported that her August 6th dental coverage payment included a hand written note in a box at the bottom of the payment which identified that she was paying the dental only, and was requesting cancellation of her health insurance. Exploration of the evidence showed that the appellant had kept a record of ongoing interactions with HSRI which also showed a chronological summary of events. On August 6, 2014 she writes-cancelled policy effective 9.1.14 through correspondence (unable to get her on phone) mailed Ck.1728 for dental only for Sept. with cancellation.

The appellant indicated she received a September 4th notice which indicated that her coverage would end on September 30, 2014, and she received a bill around September 3rd. She contacted HSRI, and was able to speak to a representative who informed her that the Agency had most likely not received her check, and that the only way to cancel a policy was through verbal notice. The appellant informed the agent that her check had been received and cashed; indicating her closure note with the check had been received as well. She asked to speak with a Supervisor who confirmed that she would have had to cancel verbally.

At hearing, the Agency did not confirm that the policy requires only verbal notification, nor did they dispute any of the testimony given. The Agency testified that based on the evidence presented they did believe the appellant had requested dis-enrollment 14 days prior to the end of the month, and they believed that the appellant most likely should not have paid for the month of September. They had noted the possibility of ongoing discussions with the carrier to attempt to cancel the appellant's September coverage retroactively during the held open period agreed upon for the admission of additional evidence. The record of hearing was held open for three weeks, but no additional evidence was submitted.

The appellant argued that she should not have had coverage in September. Exploration of the evidence presented shows that the appellant is required to pay monthly premiums. During some months she received tax credits, and other months she earned tax debits. It is unclear from the evidence presented whether she incurred premium

debits or credits assessed for the month of September. According to policy these tax credits are reconciled when the applicant files a tax return. The appellant contends she cancelled prior to September, and so, by inference, she is arguing against payment of any tax payments incurred as well.

In summary, policy cites that an enrollee must submit a request for termination of medical insurance at least 14 days prior to the end of the month in order to obtain termination in that month. The appellant gave credible and undisputed testimony that she attempted to contacted the Agency in August to cancel her September medical coverage. She then, on August 6th sent a statement of cancellation and a check for dental coverage only, for the month of September. This would have allowed the appellant the time frame within which to cancel without penalty. Upon determining the Agency had not cancelled her September coverage she contacted the Agency who then told her she would have had to cancel verbally. Policy indicates this is not correct, and that the 14 day notification was sufficient.

With regards to tax credit reconciliation, regulations indicate that this cannot be done except by the IRS. However, the appellant is not responsible for any adverse tax ramifications for the month of September, as a consequence of HSRI's faulty assessment which allowed continuation of the appellant's medical coverage in a month in which she should not have been covered. The appellant correctly, and per policy, requested closure of her case in August, at least fourteen days prior to the end of the month. Therefore, the appellant is not responsible for any health coverage premiums and/or tax penalties incurred for the month of September 2014.

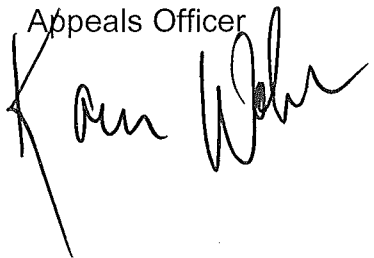
After a careful review of the Agency's regulations, as well as the credible and undisputed testimony given, the Appeals Officer finds that the appellant's request for relief is therefore granted.

Please note that the final calculation of tax credits is conducted by the federal Internal Revenue Service through the reconciliation process, in accordance with section 36B(f) of the Internal Revenue code, and that decisions or interpretations of the EOHHS appeals office are not binding against the IRS during that process.

ACTION FOR THE AGENCY:

HSRI is to rescind the September 2014 bill. Upon reconciliation of the end of year tax credits, HSRI is to insure that the appellant is not responsible for any tax penalties or payments incurred for the month of September.

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.

SECTION 5.0 ADVANCED PAYMENTS OF THE PREMIUM TAX CREDIT

5.1 **In General.** Section 1401 of the ACA creates new section 36B of the Internal Revenue Code (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 of the ACA establishes provisions aimed at reducing the cost-sharing obligations of certain eligible individuals enrolled in a QHP offered through an Exchange, including standards for determining Indians eligible for certain categories of cost-sharing reductions. The ACA and its implementing regulations, found in 45 C.F.R. §155.305, authorize the Exchange to determine qualified individuals' eligibility for Advance Payments of the Premium Tax Credits. In order to qualify for Advance Payments of Premium Tax Credits, an applicant must meet both the eligibility requirements to enroll in a Qualified Health Plan as described at §3.0 of these Regulations and the eligibility requirements for the advance payment of premium tax credits as described in this subpart. An applicant determined eligible for a premium assistance amount may elect not to take the full monthly premium assistance amount for which he or she is determined eligible. The amount of the premium tax credit the applicant should have received over the course of the benefit year will be reconciled when the applicant files a tax return for that year.

5.5 **Calculation of Advance Payments of the Premium Tax Credit.** The Exchange shall calculate any applicant's advance payment of the premium tax credit in accordance with the requirements of 26 C.F.R. §1.36B-3.

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.