



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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June 2, 2015

Docket # 15-485

Hearing Date: March 31, 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:

EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES (EOHHS)
MEDICAID CODE OF ADMINISTRATIVE RULES (MCAR)
SECTION: 0110.50 Appeals Officer
SECTION: 0110.55 Hearing Procedure

**RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH
BENEFITS EXCHANGE (RIHBE)**
**SECTION: 4.0 Initial Open Enrollment, Annual Open Enrollment, and Special
Enrollment Periods**
SECTION: 4.1-SECTION: 4.6
SECTION: 7.0 Termination of Coverage and Grace Periods

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, Lindsay Lang, and David Dee.

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

ISSUE: Should the appellant receive retroactive health coverage as of January 1, 2015?

MCAR RULES AND REGULATIONS: Please see the attached APPENDIX for pertinent excerpts from the Rhode Island Executive Office of Health and Human Services Medicaid Code of Administrative Rules (MCAR).

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:

- We are aware that sometimes the signing up and the notices can be confusing.
- We are only in our second year of operation, and we still have some technical glitches that we are working out, especially in the enrollment part.
- A lot of members have told us that it would be easier if they could automatically re-enroll, but we didn't choose to do that for a number of reasons.
- There was a general notice sent out on December 12, 2014 sent to everyone; and a December 18th notice identifying open enrollment, and that HSRI will not automatically renew, and instructions for signing up in order to obtain January 1, 2015 coverage.
- From the Agency's perspective, we have a record that the appellant first called us (HSRI) for coverage for 2015 on January 9th.
- He told us he had initiated a plan prior but the representative told him they did not see any record of that attempt to sign up in the account.
- The first eligibility notice for 2015 coverage was sent on January 3, 2015 and informs the appellant that his coverage start date at the earliest would be February 1, 2015 if he were to pay on time.
- That notice also identified that "you have not yet completed enrollment in a plan."
- We also have a record that he made his first payment on January 12th, and received another notice on January 16th that confirmed he had enrolled in the plan and had paid for that plan. Based on those enrollment dates, and payment dates that would give him an effective coverage start date of February 1, 2015.
- From our position we do not have a record of him selecting a plan before January 2015. Based upon that he would not be eligible until February 1st.

- There are instances where a person has technical difficulty signing up and we have allowed backdating, but those are specific circumstances depending upon what the difficulty was.
- There also might be hardships or a medical difficulty which actually physically prevents someone from signing up, but it is unclear if the facts in this case would allow that.
- There should be a record of a log-in, and HSRI should be able to show that someone using his log-in went into the account and made changes on December 30th. We could definitely look into this.
- My understanding is that the signature is requested during the application. If he went through the signature page and he actually finished the process, we could see that.
- I don't believe you could get to the signature page without going through the process.
- I can't confirm if the signature page is the last page of the enrollment application.
- My understanding is that the summary page would be before the signature page.
- We would like to explore whether there were technical difficulties signing up and if it was confusing to the extent that he believed that he had signed up (and had not)-if there was an error in our system which made it appear as if he reasonably believed he had signed up.
- Given his medical condition at the time, there could possibly be extenuating circumstances which incorporate both the medical hardship and the technical difficulties with the system which we would like to explore.
- It would be helpful if we had a copy of the initial dashboard, because it can't be obtained now.
- We will need to see how far he (the appellant) got in the process, and whether we can confirm based upon what he did, that he made the attempt and that there was a reasonable expectation that he had signed up.
- If he had enrolled prior to the end of December 2014 he could have had January 2015 coverage.

- We will provide information about him (the appellant) logging in on December 30th, and the activity that took place on December 30th, and whether it corresponds with his records.
- We could also provide a flow chart of the enrollment process and where the summary and signature page are in that process.

The appellant testified:

- He initially enrolled in January 2014 with HSRI and added his child on in May and was dis-enrolled in June, and in September there was a dis-enrollment and things were very confusing but things were reinstated going back to the beginning of the month he was supposed to have coverage.
- He initially met with a representative when he first signed up (Jan.2014), and he called a Navigator during the year when he had been dis-enrolled and re-enrolled twice do to some problems with the system.
- In December 2014 he received a notice that his benefits would cease as well as hearing a number of advertisements which established that he had to re-enroll.
- In early December he went to a dermatologist and had a mole removed, which was then biopsied, and he waited through the holidays for results.
- He realized he was getting late for re-enrollment, so on December 30, 2014, he logged on to the web site and initiated the process of re-enrollment.
- He was still enrolled in December 2014 and attempted to re-enroll by logging on to the website on December 30th.
- He doesn't recall the process being the same as his first enrollment when he enrolled earlier, and doesn't know if it was changed over the past year.
- From his experience of enrolling in 2014 he used his knowledge from the previous enrollment where he had just filled in a couple of check boxes, and thought the current enrollment would be carried through the new year.
- He went through the process on the HSRI web site, and came to a summary page which he reviewed, and which indicated something to the effect that it was successful.
- He then came to an e-signature page which he signed, and there was another page which said results. He then logged out.
- His contention is that the signature page and the summary page came prior to him needing to select a plan.

- He is submitting a screen capture from his browser history which shows his activity logging onto the website and attempting to re-enroll on December 30th and then again his enrolling on January 9th.
- He feels that his signature followed by application summary demonstrates his intent to re-enroll and sign up within the time frames.
- After the new year the doctor told him his biopsy results were cancerous, and he needed to immediately have a procedure because time was of the essence.
- He had the procedure around January 8th, and upon leaving the office he was notified he did not have insurance.
- He was mid-diagnosis with this issue, and certainly would not have let his insurance lapse knowing that he was possibly facing malignant cancer which he ended up having.
- He contacted HSRI the minute he found out there was a problem.
- He had contacted HSRI, according to his phone record, probably late the night of his doctor's appointment which he later determined was January 8, 2015.
- He spoke with someone at HSRI the following day.
- He wants to point out there is a standard Health Election form (submitted) for the Federal employees health benefits program, and the last section filled out during re-enrollment is the signature.
- His understanding from this form and his past experience enrolling in anything is that the last part of the process for re-enrollment is the summary and the signature. He has never been asked for a signature or been given a summary half way through the process.
- He may have been a little "scatter brained" at the time, due to his medical diagnosis and concerns, and might not have given the sign-up all the attention it needed.
- He tried to get a copy of the initial dashboard, but he couldn't get it after the fact without signing up again and possibly confusing the system.
- The dashboard in the record is the newest dashboard and he was unable to get both the initial dashboard, and the initial results page.
- He thought he was enrolled, and the cards that he has have the same number as the cards used in 2014.

- He's trying to ascertain when in the enrollment process do you (HSRI) ask for a signature.
- Do you (HSRI) have the process of re-enrollment outlined in terms of the flow of how the re-enrollment or enrollment process goes according to the consumer's process and log on?

FINDINGS OF FACT:

- A December 30, 2014 Notice informed the appellant he was losing his coverage as of December 31, 2014 for the reason-end of plan year.
- The appellant filed a timely appeal on January 13, 2014.
- A January 3, 2013 notice thanks the appellant for applying for health coverage through HSRI, and indicates he has not yet completed enrollment.
- A hearing was held on March 31, 2015.
- The record of hearing was held open until April 21, 2015 for additional evidence.
- On April 20, 2015 the appellant requested by email, an opportunity to rebut any evidence submitted by HSRI. This was granted at that time.
- No additional evidence was noted during the held open period.
- Following receipt of the hearing decision completed on April 27, 2015, HSRI sent this office an email which showed proof of follow up evidence which had been sent to this office on April 20, 2015-one day earlier than the held open date, and which had not been considered in the evidence.
- The appellant was contacted on April 30th, and informed that the decision which had been completed and not yet received by him would be vacated in order to allow the original evidence sent and previously omitted-to be considered. Per the appellant's request of April 20th, and per his request on April 30th to rebut any evidence sent by the Agency, the record of hearing was reopened and the held open period was extended to May 15, 2015. The appellant was offered a reconvene if desired which he chose not to accept.
- A Vacated decision dated May 1, 2015 was sent to the appellant and the Agency indicating the accidental omission of previous and timely evidence, the subsequent vacated status of the initial decision, the allowance and consideration of the new evidence in order to fully develop the record, and the extension of the held open period to allow rebuttal.

- Rebuttal evidence was sent by the appellant during the second held open period.
- The appellant, in a May 15th correspondence disputes having ever received the evidence sent by the Agency prior to the April 21st deadline (first held open), and requests that the evidence be considered inadmissible as a result of his lack of receipt prior to the initial held open deadline. He further submits that the initial finding be re-instated.
- The appellant was sent or re-sent the evidence (referenced above) on May 1, 2015. He submitted a response to that evidence on May 15, 2015. That evidence has been considered in this decision.

CONCLUSION:

The issue to be decided is whether the appellant should receive retroactive health coverage as of January 1, 2015.

Regulations specific to the RI Health Benefit Exchange (RIHBE) identify that to make coverage effective, qualified individuals must select a Qualified Health Plan (QHP) and submit the balance of the first month's payment in full in accordance with dates established by the Exchange.

There is no dispute that the appellant did not select a health plan prior to January 1, 2015. Subsequently, his health insurance terminated on December 31, 2014, and he was not re-enrolled for 2015. There is no dispute as well that the appellant was aware through both a November 2014 Annual Open Enrollment notice and via a number of advertisements, that his existing coverage would be terminating in December, and that re-enrollment was necessary prior to that date in order to maintain coverage on January 1, 2015.

The appellant testified that he had a mole removed in December for which he anxiously awaited biopsy results through the Holidays. He testified that on December 30th, he realized he was getting late for re-enrollment and logged onto the website to initiate the process. He stated that he completed the process by obtaining access to the summary page, followed by an E-signature page which he signed, followed by a results page, and a successful log out. He testified that a request to pick a plan was not presented prior to this signatory page inserted in the middle of the process. As a result, he thought he was enrolled, and that his existing coverage plan would continue. He contends that the "ongoing pattern of disorganized communication and errors" as evidence by his prior HSRI issues, and his previous (2014) notice confirmation experiences supported his assumption that he had re-enrolled and had simply not received timely notice. The appellant opined that his life experiences as well as the Federal employees' health application (submitted into evidence) demonstrates that the final step is often the signature page on other applications. Post hearing, the appellant sent a written response and fourteen email attachments to further support his position. He identifies that he has "successfully demonstrated that he (I) can use the on-line enrollment form at

least two times prior to December 30th, 2014.” He argues that he had established enrollment, billing and payment and that he can navigate successfully. He further argues, and submitted evidence supporting his enrollment difficulties. These included copies of articles referencing public acknowledgement of the many re-enrollment issues and the technical difficulties, as well as copies of enrollment notices he has received in reference to his HSRI accounts. The appellant further argues that the juxtaposition of the signature page inserted in the middle of the application led him to assume he had completed the process. The Agency, through evidence sent post hearing, argues that the Signature Page was a page which indicates an understanding that the applicant’s signature would serve as an ongoing copy of his electronic signature for the document. He further testified that throughout the application the appellant had already been prompted to continue from page to page by a “NEXT” button provided on the bottom right hand corner of each page. He argues that this page was no different, and that had the appellant followed the same chronology and prompt, he would have found himself at the “Submit Your Application” page which asks if you would like to proceed. The Agency further contends that the eSignature page displays no “typical completion language” which would have suggested that he had completed/and or submitted an application. The Agency did not contest the appellant’s claim that he initiated an on line attempt for application on December 30th.

In exploring the evidence submitted by both parties, the appellant’s evidence presented at hearing included a snap shot of the chronology of the on-line application process as observed through a screen shot displaying “health source” search history from October 31, 2014 through January 9, 2015. The chronology displays the headings for each step taken on his HSRI account. The order of headings shows-first, an application summary; followed by an ESignature page; followed by a Results page; followed by a successful logout page. The Chrome history supports the appellant’s contention that he initiated sign up on December 30, 2014. The evidence showed that he was active on his Health Source account on that date. Post hearing, the Agency presented a series of screenshots developed in April 2015 which show snapshots of the actual application pages, and records the percentage of completion reached by each page. Exploration of the evidence shows that the first page prominently displays a bright green button in the bottom right hand corner which reads “NEXT”. In order to proceed, the appellant pushes “NEXT”. The second page-Application summary (created at 2% of application completion) requires “NEXT” in order to access the third page-ESignature, which also prominently displays the “NEXT” button in order to move forward to the page never accessed by the appellant-the “Submit Application” page. In support of the Agency’s claim, the appellant had already followed this instruction on the prior pages. The Authorization for HSRI to request Income Data was included on the bottom of the page also. Boxes for agreement were checked by the appellant. It read: “**Before** (highlighted for emphasis) you continue we require you to acknowledge the following,”.....The wording on the page itself then, had recommended to the appellant, that he would be continuing or proceeding. Thus, the NEXT button which had prompted the appellant on the previous pages was overlooked by the appellant on this particular page, when it had not been overlooked on the preceding pages. The appellant testified to, and submitted further written documentation which shed some light on how this might have happened. The appellant wrote with regards to his overriding medical concerns, “The duress of the

situation, and the urgency to have the malignant melanoma removed was a priority in my life. I believe the procedure was performed within five or six business hours of being notified that the biopsy came back positive.” The appellant testified repeatedly that his emotional frame of mind may also have affected his ability to complete his sign up in that he might not have given the application all the “attention it needed”.

Evidence submitted shows no dispute between the appellant and the Agency with regards to the order of the pages-Application followed by e-Signature. Both parties submitted evidence indicating that the Results page was generated immediately prior to completion. The results page entered into evidence referenced a summary of activities for the applicant at that point in the process. It also included a request for anything not yet completed. In the example presented, the document notes that in order to enroll, “you will need to provide more information.” It can be assumed that similarly, the results page presented to the appellant prior to Log-out included some summary of his progress and activities up to that point. The appellant was unable to obtain a copy of his results page which might have clarified his assumption of completion. Despite the appellant’s persuasive argument with regards to the comparison of the e-signature page location in the middle of this document and the e-signature page always located at the end of other types of documents-i.e.: federal/state applications submitted-it is this specific 2015 HSRI application which is in question.

The appellant further testified that he had been to the doctors in early December and had a biopsy for which he awaited the results through December. When his test results determined malignancy, the doctor asked that the appellant obtain immediate surgery because “time was of the essence.” The appellant had a medical procedure on January 8, 2015 and was told, upon leaving the doctor’s office, that he had no medical coverage. He spoke with an HSRI representative on January 9th who told him there was no record of his having attempted to sign up in the account prior to that date. The appellant further contends that he would not have chanced the possibility of no insurance as he was awaiting the results of a biopsy from early December on, and was anxious about the possibility of a cancerous diagnosis. He further testified that a November 2014 notice identified the re-enrollment period coming up; and the December notice had indicated the closure of his current insurance on December 31st. He began sign up on December 30th. He did not see any online notices until after the surgery, and noted that the January 16th notice indicated that coverage began on February 1, 2015. The appellant argues that his initial 2013 HSRI sign up was on December 23, 2013 (for eligibility on Jan.1, 2014). This was followed by a January 3rd bill, which was followed by a January 11 notice requesting additional information, which was followed by the eligibility notice on January 16, 2014. He thus concluded that the inconsistencies year to year and his lack of timely confirmation for eligibility in mid-January helped lead him to the conclusion that he would not receive notification until later in January, and thus assumed, as in the past, he was covered. The Agency testified that the November notice was a general open enrollment notice which was sent to all applicants. The Agency directed attention to the portion of the notice which read, “You must renew through HSRI, pick a plan and pay for it by December 23, 2014” to insure coverage begins on January 1, 2015 and you receive your insurance cards before the year starts. The Agency submitted into evidence the December 30th notice identifying the end of year plan on December 31,

2014. He further testified that although the Agency had no record of a December 30th attempt to enroll, the appellant had received an eligibility notice on January 3, 2015 which informed him that his earliest coverage start date would be February 1, 2015 if he were to pay on time.

Exploration of the November notice submitted by the Agency demonstrates that the appellant must contact HSRI to renew coverage by December 31, 2014 or he will not have coverage beginning in January 2015. It further notifies that no customers will be automatically renewed resulting in no "health insurance for the upcoming year, so you must contact us to avoid a break in health insurance coverage." Exploration of the appellant's 2013 notices and testimony indicates that in the past, the appellant did complete both application and insurance selection prior to January, as the January 3rd bill he received was a bill which is generated following the selection of a specific plan and carrier. He did not receive an eligibility notice until later in January, but did have ongoing conversations with HSRI through the notice requests from the time of application to the time of eligibility. Unlike the previous year, the appellant this time attempted to apply for health insurance on December 30th, but did not complete the application or choose a plan, which would notify the Agency that he wanted coverage. As a result, the Agency was unable to corroborate his testimony that he had applied in December because they were unaware the appellant had attempted to sign up. Additionally, unlike previous enrollments, this was Health Source Rhode Island's first re-enrollment. Thus, the procedures would not necessarily replicate the first **open** enrollment in 2013/14. The January 3, 2015 notice informed the appellant he had not completed enrollment in a plan. It further read that more information was needed and that instructions for "how to enroll in a plan" could be located in the notice. The notice indicated a starting date of eligibility of February 1, 2015. The appellant testified post hearing that he did not "even think to log on to his (my) HSRI portal to confirm that the re-enrollment process "had been confirmed when in prior years (as discussed) it was confirmed in mid-January. The appellant testified that he had immediate surgery on January 9, 2015. The first notice was generated on January 3rd. The appellant had 5 to 6 days between the notice generated on January 3, 2015, and the receipt of the biopsy results sometime around January 8th. In that period he had an opportunity to contact HSRI to discuss the lack of enrollment, and the stated effective coverage date beginning on February 1, 2015. He had time as well to make sure he had coverage for the possibility of upcoming medical concerns. The procedure was arranged around January 8th, and took place on January 9th when the appellant had no coverage. The testimony is unclear as to when the medical community noted the appellant's lack of coverage, except to identify, that upon leaving the office, he was informed. In summary, the appellant did not have coverage at that time, due to an omission to look at his on line HSRI notice generated on January 3rd, and due to the omission of the submission of the online application. Had he checked his mail, he would have been informed that he lacked coverage, was not currently enrolled, and that the earliest possible starting date for coverage was now February 1, 2015.

Regulations identify that to obtain coverage the applicant must choose and pay for coverage prior to enrollment-neither of which occurred. In 2014, the first year of operation, some leniency might have been allowed towards actual payment following

selection of a plan; which in turn allowed the appellant coverage on January 1, 2014, and payment on January 3rd. Procedurally, this might still occur in 2015. However, the appellant's December 2014 notice (for 2015) identifies "Important Dates". December 23rd is so noted as the date by which the enrollee must pick and pay for a plan in order to insure coverage beginning on January 1, 2015.

The appellant submitted numerous newspaper articles identifying the technical difficulties encountered in the system. He cited dis-enrollment issues, the states choice for re-enrollment rather than automatic re-enrollment, and documented technical problems. He further presented credible evidence that he had numerous issues with HSRI during the first year of operation as well, and was dis-enrolled and re-enrolled on several occasions both pre and post hearing. The appellant further noted that all past HSRI (2014) issues, and "there were and still are plenty of errors", with the exception of the current appeal, were corrected once brought to the attention of the customer representatives. The Agency testified that as a second year program, there were still technical issues "especially in the enrollment part." The HSRI representative agreed to explore both the chronology of signing up; and, whether the appellant had incurred technical difficulties signing up which were confusing to the extent that the appellant believed he had signed up. Post hearing, the Agency representative apologized for the appellant's difficulties, but presented additional evidence which argued that HSRI considered the application process, and particularly the signatory page, sufficiently clear.

Exploration of the application itself has been previously considered in this decision. The article presented by the appellant support his contention that an automatic re-enrollment might have been much less problematic for many customers. The articles reinforce his argument and suggest that "there could be technical problems as many people try to enroll." The articles also consider that "most of our customers are not having problems signing up for coverage." The issue being considered for this appellant then is whether he incurred technical difficulties to the extent he could not sign up, or in his case thought he had signed up. The difficulties discussed in the article include mistaken dis-enrollment from health insurance plans, serious computer problems, a lengthier re-enrollment process, and ongoing technical problems. The appellant did not experience any of the "glitches" described in the articles, besides a more cumbersome and different enrollment process than that which he experience during his initial enrollment. His failure to complete his application may have been colored by those experiences as he credibly testified. However, he testified to his ability to navigate the system, and had already demonstrated on that application an understanding of the sign up process. He did not complete his application which in turn did not allow the Agency to insure his medical coverage.

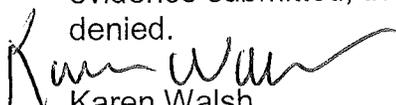
Last, the appellant argues that he did not receive the packet of evidence submitted by the Agency prior to the April 21, 2015 4:00pm deadline. Due to an omission by this office, this hearing officer did not originally consider the evidence which was sent on April 20th to this office. Regardless, upon learning of the omission the evidence was accepted, the initial decision was vacated, and this decision is hereby rendered, based upon all the facts. The appellant believes that his initial lack of receipt of evidence prior

to the held open deadline should nullify this decision and allow the initial findings to stand. In fact, regulations dictate that the hearing officer must not close the case until they are satisfied that all interested parties have had the opportunity to present the facts needed for a decision. The Agency was afforded this right upon discovering they had previously sent evidence not considered. The evidence which was shown to have been sent to this office in a timely manner was then sent or re-sent to the appellant allowing him a period in which to rebut if desired, or reconvene. He did submit substantial evidence to rebut the claims of the Agency. The time frame in which the appellant receives the evidence is not crucial. The necessity that he did receive it and was allowed to refute or argue his position is the due process consideration. Furthermore, the RI Supreme Court obligates this officer to consider new evidence. In this case, the evidence was not new, but overlooked, and was considered as part of the initial hearing, and was considered crucial to this finding.

In summary, the appellant was sufficiently notified by HSRI that he would need to re-enroll for 2015 health coverage, and that he would not automatically be re-enrolled. Notices further identified that he must select a plan and pay for a plan in order to obtain enrollment. The appellant attempted to initiate an online re-enrollment through HSRI on December 30, 2014. He testified that he thought he had completed enrollment upon encountering the e-Signature page, although he did not pick a plan or pay for a plan. The wording on the e-Signature page indicated that the application process would continue. The appellant had followed the identical instructions on the two previous pages continuing to the next page, as directed. On the e-Signature page he did not follow the instructions and did not proceed farther, resulting in a lack of submission of his application. The appellant did not receive subsequent requests for an insurance plan selection or subsequent billing requests from HSRI as indicated on prior notices as a necessity for enrollment. The appellant testified as well to his emotional state at the time of the application which he concluded may have affected his ability to focus while attempting to complete the document. As a result of the appellant's omissions, he was not re-enrolled for health coverage beginning on January 1, 2015.

The appellant had a second opportunity to discover that he was not enrolled. A January 3, 2015 notice informed the appellant that he had not yet enrolled in a plan. The appellant did not access his online mail at this time, and thus did not consider this notice. On January 8, 2015 he scheduled an urgently needed medical procedure which took place on January 9, 2015. Upon leaving the doctor's office he discovered he did not have medical coverage. As a result of the errors by the appellant, the Agency is not responsible for his failure to submit his application for coverage, and his subsequent lack of coverage.

After a careful review of the Agency's regulations, as well as the testimony and evidence submitted, the Appeals Officer finds that the appellant's request for relief is denied.


Karen Walsh
Appeals Officer

APPENDIX

RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE

SECTION 4.0 INITIAL OPEN ENROLLMENT, ANNUAL OPEN ENROLLMENT, AND SPECIAL ENROLLMENT PERIODS

4.1 In General. Section 1311 of the ACA and its implementing regulations, 45 C.F.R. §§155.410 and 155.420, establish requirements for initial open enrollment, annual open enrollment, and special enrollment periods for Qualified Health Plans.

4.2 Initial Open Enrollment Period. The initial open enrollment period as established by the Exchange shall last from October 1, 2013 and through March 31, 2014.

4.3 Initial Open Enrollment Period Coverage Effective Dates.

(a) To make coverage effective, qualified individuals must select a Qualified Health Plan and submit the balance of the first month's payment in full in accordance with dates established by the Exchange.

4.4 Annual Open Enrollment Period.

(a) *Benefit Year 2015 and Beyond.* For 2015 and subsequent benefit years, the Exchange will establish the annual open enrollment period and shall provide a minimum of one hundred twenty (120) days advance public notice prior to its first day.

(b) Annual Open Enrollment Periods as established by the Exchange shall last a minimum of thirty (30) days.

4.5 Annual Open Enrollment Period Coverage Effective Dates.

(a) Qualified individuals must select a QHP and the Exchange must receive the first month's premium in full in order to make coverage effective.

(b) *Benefit Year 2015 and Beyond.* The Exchange shall establish a deadline relative to the Annual Open Enrollment Period by which a qualified individual's first month's premium must be received in order to make coverage effective as of the first day of the benefit year.

SECTION 7.0 TERMINATION OF COVERAGE AND GRACE PERIODS

7.7 Notice. The Exchange will provide an enrollee written notice of an involuntary termination that shall include the basis of the termination at least thirty days prior to the effective date of the termination.

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.

0110.50 THE APPEALS OFFICER

REV: 08/2013

The hearing shall be convened by an impartial designee of the Secretary of EOHHS. No person who has participated in the pertinent matter under review shall be eligible to serve as an appeals officer.

The appeals officer shall endeavor to bring out all relevant facts bearing on the individual's situation at the time of the questioned state agency action or inaction and on state agency policies pertinent to the issue. The hearing shall not be closed until the appeals officer is satisfied that all interested parties have had the opportunity to present the facts needed for a decision.

0110.55 THE HEARING PROCEDURE

REV: 08/2013

The hearing shall be recorded. Any person who testifies at the hearing shall be sworn in by the appeals officer. An orderly procedure shall be followed that includes no less than the following:

- A statement by the appeals officer reviewing the state agency's purpose relative to the hearing; the reason for the hearing; the hearing procedures; the basis upon which the decision will be made, and the manner in which the individual is informed of the decision.
- A statement by the claimant (or his/her authorized representative) outlining his/her understanding of the problem at issue.
- A statement by the state agency representative, setting forth the state agency's policies under which action was taken or denied.
- A full and open discussion of all facts and policies at issue by participants under the active leadership of the appeals officer.

The hearing may be adjourned from day to day or to a designated day when either the appeals officer and/or the individual needs time to obtain further information.

0110.55.05 ADMISSIBLE INFORMATION

REV: 08/2013

Only information bearing directly on the issue under review and the supporting policy may be introduced from agency records. The appeals officer shall not review any information that is not made available to all interested parties.

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.