Rhode Island Executive Office of Health and Human Services
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June 23, 2015

Docket # 15-733
Hearing Date: May 12, 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: 4.0 Initial Open Enrollment, Annual Open Enrollment, and Special Enrollment Periods
SECTIONS: 4.1-4.5

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, David Dee, and Lindsay Lang.

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

ISSUE:
Should the appellant receive reimbursement/and or credit for health premium payments submitted for coverage months in which he did not receive coverage.

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:

- There does not appear to be a policy issue.
- He (the appellant) called on December 24, 2014, and customer service representative assisted him on the phone with enrolling him into a plan and taking his first month's premium.
- Our assumption would be that the coverage start date would begin on January 1, 2015, because people are enrolling for the next coverage month, and because he enrolled on the 24th it suggests he is not looking for December coverage.
- He came into the facility on January 20th with a bill showing that he did not have a current amount due (for February) because the payment he made on December 24th was applied for December rather than January, and as a result he was not enrolled.
- At that time he was assisted in enrolling in United Health care and he should have had a February 1 enrollment date.
- He requested a refund of the December payment and he paid for February coverage at that time.
- There is a system wide issue that has occurred from the beginning of the year, in that when people enroll in United they are not showing up as active, so he did not appear active in February either.
- The customer service representative gave him the impression that there was resolution, as no one knew there was this issue and that he would not show eligible for February either.
- For the months of January and February he was not actually enrolled.
- There was a January 24th notice stating he had coverage beginning on February 1st, but that did not happen.

- There were no other notices besides a 1095 tax document, until April when he was told that he had been covered retroactively.

- From our communication notes (HSRI) a customer representative did tell him he was not in the system.

- It could be assumed that the payment he made on March 18th was most likely for April coverage.

- It now appears he was active as of April 1, 2015.

- There was no reason for him to appeal before March, as the Agency had told him he had no issues, and he had no reason to assume there was an issue.

- We are not disputing the payments in December and January.

- When we go back and retroactively "scrub" the amount for services because there was no coverage, we also remove the APTC's incorrectly incurred.

- There is a federal policy indicating you must have coverage for at least 10 months, but exemptions can occur if there is error on the part of HSRI.

- Following receipt of a decision, if the lack of coverage is caused by HSRI, he would need to apply through HSRI for the exemption and they would approve this and it would be sent to the IRS at tax time next year.

- We are not disputing the issues, but we will use the held open period to determine that there are no other facts outstanding, as well as to work towards reconciliation.

The appellant testified:

- He agrees with the timelines as presented by HSRI.

- He did enroll on the 24th of December, and paid $185.44; then went into Health Source on January 20th, as the bill showed no new charges for February.

- He was told to he had not been enrolled, rates had changed, and he was to select another carrier, so he chose the United plan coverage, and paid $248.84 with the understanding the coverage would begin in February.

- At the visit with HSRI on January 20th he asked that the December monies be refunded or used toward credit for future coverage, which they told him they had

already been addressing in the system.

- On January 24th, 2015 he received a summary of coverage verifying that he had coverage as of February 1, so he was satisfied that there were no issues.

- When he did not receive any cards, and after receiving a bill for March 2015, he made an appointment with a representative on March 18th.

- On March 18th, he met with a customer representative, found out for the first time he was not in the system, and filed an appeal. Up to that point, he had understood since December that the system would catch up to him, and there were no issues.

- The customer representative determined that he was not ever enrolled in coverage in United Health, and she contacted the carrier.

- She explained that the error was on the part of the carrier.

- She had him pay only one month, because so much credit was already owed him.

- He paid in March with the assumption he would have April coverage, and he did receive cards after that, and appears to have coverage.

- He had been writing checks for months in which he was not insured, and as a result he did not go to the doctors and did not use his coverage.

- At this time he is looking for the December payment of $185.44, and the January payment of $248.84 to be refunded or credited towards his account.

FINDINGS OF FACT:

- A March 18, 2015 appeal was filed by the appellant.

- Timeliness was accepted at hearing.

- The appellant made a payment of $185.44 in December 2014 for January 2015 coverage.

- A December 31, 2014 notice identified that the appellant had coverage effective December 1, 2014.

- The appellant made a payment of $248.44 in January for February coverage.

- A January 24, 2015 notice identified that the appellant had coverage effective

February 1, 2015.

- The appellant was not enrolled in the HSRI system until April 2015, and did not receive health coverage until April 2015 following his payment in March.

CONCLUSION:

The issue to be decided is whether the appellant should receive reimbursement/and or credit for health premium payments submitted for coverage months in which he did not receive coverage.

Regulations specific to the RI Health Benefit Exchange (RIHBE) identify that the Exchange must receive the first month's premium in order to make coverage effective on the first day of the following month.

There is no dispute that the appellant signed up for January 2015 coverage in December 2014, and paid his first month's premium at that time. There is no dispute that the initial notice incorrectly identified that the appellant would be covered beginning on December 1st retroactively. There is no dispute that the appellant signed up a second time for coverage beginning on February 1st, and paid a premium for that coverage. A second notice in January 2015 identified that the appellant would be covered as of February 1, 2015. There is no dispute that the appellant was never enrolled in the system and did not have coverage until April 2015. There is no dispute that the appellant paid for his April coverage in March.

The appellant testified and the HSRI representative concurred that the appellant signed up for January coverage in December 2014 and paid his first premium. In January 2015 he went into the facility to question his lack of receipt of a bill for February coverage. He found that he had not been enrolled in the system. He then chose a different carrier due to a change in the cost, and paid for coverage going forward beginning in February. He was told the Agency was attempting to rectify his past premium which had been incorrectly assigned to December coverage. The appellant made an appointment with an HSRI representative in March because he had not received his health insurance cards as expected. At that time, an HSRI representative informed him he was still not enrolled in the system, and the issue was with the carrier. The appellant filed an appeal in March, which was accepted at hearing as timely, due to the incorrect information from HSRI prior in which he was told his issues had been reconciled. The appellant paid in March for coverage effective April 1, 2015 and testified that he received his health cards shortly afterwards.

The HSRI representative at hearing further testified that there was a systems wide issue for United Health insurance recipients which resulted in the applicants not showing up as active. The Agency supported the appellant's testimony in all areas, and agreed that the case should be reconciled by a return of the December and January payments as a result of the appellant's lack of coverage. The Agency further testified that any APTC's incurred in December would need to be removed if the appellant was found not to have coverage in that month. Furthermore, the Agency identified that the appellant would be allowed an exemption by HSRI for his lack of coverage if the Agency was found to be at fault. He did not dispute that the Agency was at fault.

In summary, the appellant applied for, chose a plan, and paid for medical insurance through HSRI in December 2014; which per policy, should have begun on January 1, 2015. The appellant subsequently chose a different carrier and paid in January for coverage to begin in February. The appellant never received any coverage as he was not entered in the HSRI system, or the United Insurance system, or both, until April 2015. The Agency concurred with the appellant's request for relief, but to date, the Agency has not withdrawn or corrected their denial notice, or made the appellant whole. As the appellant paid for a service/product which he did not receive, he is owed reimbursement/and or credit for the two premiums he incurred in December ($185.44) and January ($248.44). Because the appellant incorrectly received a notice identifying coverage for December 2014, which he did not want, and did not receive-he was also incorrectly assessed for APTC's for that month. Additionally, the Agency is at fault for the appellant's lack of continued health coverage, due to no coverage in January, February, and March 2015, as required by regulations.

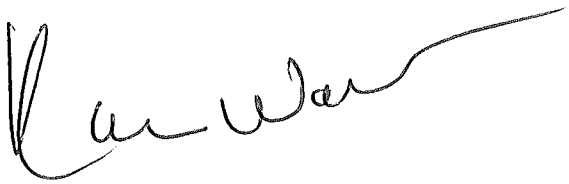
After a careful review of the Agency's regulations, as well as the credible and undisputed testimony given, the Appeals Officer finds that the appellant's request for relief is therefore granted.

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 EPOHHS appeals office are not binding against the IRS during that process.

ACTION FOR THE AGENCY:

HSRI is to ensure that the appellant receives reimbursement/and or credit for his payments made in December 2014, and January 2015. HSRI is to insure that the appellant is not charged with any APTC's for the month of December 2014. The Agency

is to assist the appellant in filing an exemption, and accepting responsibility for the appellant's lack of health coverage as required by the federal regulations.



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.

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.