



Rhode Island Executive Office of Health and Human Services
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May 8, 2015

Docket # 14-2207

Hearing Date: March 26, 2015



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

SECTION 4.1 In General

SECTION 4.6 Special Enrollment Periods

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, David Dee, and Lindsay Lang.

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

ISSUE: Should the appellant have incurred any premium costs from October through December 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 Health Source Rhode Island (HSRI) representative testified:

- HSRI did send an enrollment notice, but from our understanding Blue Cross or the carrier never sent her any cards or information she needed in order to use her benefits.
- From my understanding of the facts-when she tried to use benefits that she paid for she was denied service.
- We do not contest that this happened.
- We are trying to make sure that if she did not receive the benefits for which she paid, for the month that she tried to use services that she can get reimbursed for that month of coverage.
- I would have to double check how the notice got sent. We do send to individuals who request paper mail, so it's possible it was sent or not sent to the correct address. Regardless, she never received her card and wasn't able to use her benefits.
- The Medicaid termination on August 16th which might have triggered a special enrollment period allowed for her to sign up in October.
- There are events which cause you to be eligible for a plan which allow special enrollment.
- She was able to sign up in October so there must have been consideration for special enrollment.
- Eligibility for special enrollment would have begun the first of the following month which would have been November 1st.
- Annual open enrollment started on November 15th, and that coverage would have started on December 1, 2014.

- HSRI generates the bills, and we can get copies of the bills and we can submit them into evidence.
- From the facts as she is telling them, and we are not disputing those at this point- customer service told her she would start by November 1st.

The appellant testified:

- She never saw any HSRI notices until shown the notice at hearing. She never received any mail to her home from HSRI prior to filing the appeal.
- She never chose to have email receipt of information, she chose paper.
- She went to HSRI in October and chose her coverage, and was told she must pay by October 26th which she did.
- They told her she would be covered for October to November, and she thought she would get her next bill in November.
- She never received a bill in November.
- On November 20th she had a doctor's appointment and she was told by the secretary that she did not appear in the Blue Cross computer as no information was ever sent to them.
- She left the appointment and went to HSRI on the same day, and spoke with the representative Caswell Vegas.
- When he checked in the computer, she was not there-her paperwork was not there. They did not call Blue Cross and her paperwork was never received.
- She then spoke with a Supervisor and asked for resolution because she had paid for something she did not receive, and had not ever received anything including cards.
- When she went into HSRI in November she informed them she wanted out of the insurance immediately, and no longer wanted coverage, but wanted her money back as she had not gotten services.
- She was told it was fixable and HSRI would send the paper work immediately, but she repeated she did not want it any longer.
- The representative informed the appellant she would have to appeal, and the appellant asked why that was necessary as she had already paid for services never received.

- Following her application for an appeal in November, she received her first information in the mail, which was the hearing notice (sent by appeals office).
- The first bill arrived in the mail in December, but prior to this, she never actually received anything in the mail from HSRI. Because of this, she had called instead in October to determine what she owed, because she was not receiving anything.
- She used to get insurance from her employer which ended around April.

FINDINGS OF FACT:

- A Medicaid termination notice was generated on August 16, 2014.
- A 60 day special enrollment period is allowed by HSRI following a triggering event; such as loss of minimum essential health coverage.
- Eligibility for enrollment in a special enrollment period following payment of the first month's premium coverage is the first day of the following month.
- The appellant applied for health coverage in October 2014 and paid for her first month's coverage prior to October 26th.
- An October 28, 2014 enrollment notice identified that the appellant had successfully enrolled in medical coverage, also identified her monthly bill, and noted the effective beginning coverage date as December 1, 2014.
- The appellant filed a timely appeal on November 20, 2014.
- Open enrollment for HSRI began on November 15, 2014 with an effective eligibility date of December 1, 2014.
- A hearing was held on March 26, 2015.
- The record of hearing was held open until April 23, 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 should have incurred any premium costs from October through December 2014.

Regulations specific to the RI Health Benefit Exchange (RIHBE) identify that the Exchange shall provide special enrollment periods lasting a minimum of sixty days during which a qualified individual may enroll in a Qualified Health plan (QHP). The loss of minimal essential coverage is one such "triggering event" which would allow receipt of special enrollment consideration. The Exchange (HSRI) 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 a Medicaid termination notice was generated on August 16, 2014. There is no dispute as well that the appellant applied in October for coverage through HSRI as evidenced by an October 28th eligibility notice. There is no dispute that she paid for her first month's coverage prior to October 26th, and that she had no coverage in November when she attempted to attend a doctor's appointment.

The appellant went into the HSRI facility in October 2014 and applied for health coverage. She testified that she believed her coverage would begin November 1st per information received from the representative. She was told she must pay for this coverage by October 26th which she did. Her initial enrollment notice, generated on October 28th indicated that her coverage would not begin until December 1st. Special enrollment allows coverage to begin the first day following receipt of payment. Thus, if the appellant was being considered for special enrollment, coverage, then after she made the October payment, then coverage should have begun on November 1st.

The HSRI representative identified that an August 2014 Medicaid termination notice which should have terminated coverage at the end of that month may have been the triggering event which would have allowed a special enrollment. He testified that if under special enrollment considerations, the appellant had signed up during the 60 day period, which allowed for coverage to begin on November 1st following her payment in October. He further opined that coverage for the open enrollment period begun on November 16th would have reflected the December 1, 2014 eligibility date which was reflected in the notice. However, he testified that the appellant should not have been considered for the open enrollment time frames in October. He concluded that there must have been consideration for special enrollment because she was able to sign up in October prior to open enrollment in November.

The appellant testified that she attempted to utilize medical services on November 20th and discovered she had no coverage, and was not in the Blue Cross system at all. She left the appointment and went to HSRI directly where she was also informed that she was not in the computer, and consequently Blue Cross had not received any paper work. She asked for her money back, and cancellation of her policy going forward as she had been paying for something she had not received. The appellant testified that an HSRI Supervisor told her this could be rectified and that the paperwork could be sent immediately. She continued to request a return of her money and cancellation of the policy going forward. She was told there was no resolution and advised to appeal-which she did. The HSRI representative present at hearing testified that currently, the Agency

is trying to insure that if the appellant did not receive benefits for which she paid, and for which she attempted to use, she should get reimbursed for that month of coverage.

After paying her first premium in October, for November, the appellant received no November bill. In December, the appellant testified that she received her first bill from HSRI. Historically, bills received in one month reflect coverage for the following month- in this case the December bill would reflect January coverage. If HSRI was still considering the appellant eligible using the eligibility date of December 1st which was cited on the notice, they would have expected the first payment from the appellant in October to cover December, and they were billing the appellant for the next month of coverage which would have been January. However, the appellant had given the Agency ample time to close out coverage when she visited the HSRI facility in October.

The last and overriding consideration for the appellant was her undisputed credible testimony that she never received any notices from HSRI in the mail although she had requested paper notifications when first applying for health insurance in October 2014. She testified that she had never received any written documents from HSRI except the December bill. She noted that her first mail received was the notice of her scheduled hearing appointment sent on February 27th, 2015. This notice was not sent by HSRI, but was sent from the Appeals Office. She further testified that she had not received any bills initially but had called HSRI in October to ask about her bill which she then paid on October 26th as a result of that phone call. She never received a notice or bill from HSRI until the first December bill, which the Agency testified, are generated from Health Source. Due process demands, per the US Supreme Court, that the appellant has a right to a notice telling them what is happening, why it is happening, when it is happening, and that they have a right to appeal. In this case, it is possible that if the appellant had received her initial October 28 notice in the mail, she may have appealed immediately, or notified the Agency of the incorrect starting date, or discussed the possibility of special enrollment status. Lack of the notice precluded any of those choices. It was not until her visit to HSRI in November that she discovered her lack of insurance during a medical appointment. She then went down to HSRI where she received verbal notification of her right to appeal.

In summary, the appellant applied for medical insurance through HSRI in October 2014. Due to her loss of coverage per a Medicaid denial in mid-August she should have been allowed a special enrollment period. That special enrollment period would have ensured her coverage beginning November 1, 2014 following her October payment of the premium. She gave undisputed testimony that she was told her coverage would start on November 1, 2014. Her coverage did not start on November 1. The notice generated on October 28th indicated her coverage would not start until December 1st. A bill in December suggested as well that the Agency was still considering that the date of eligibility was December 1, 2014 but this date coincide with those enrolling in the open enrollment period. The appellant was not eligible for open enrollment due to her enrollment which took place prior to the open enrollment time frames. The appellant, after discovering her lack of coverage, made a verbal request in November that future coverage be terminated, and that her money be reimbursed, as she had paid for a

product she had not received. She was not billed in November suggesting that she had been dis-enrolled as requested. However, she testified that she received a bill in December. The appellant further testified that she had never received any notifications from HSRI in the mail about her coverage. As a result of this lack of due process, and the appellant's payment for a product which she did not receive, and the mistaken starting dates of coverage as indicated by the eligibility date which corresponds to a different enrollment period, this hearing officer finds for the appellant.

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 AGENCY:

HSRI is to ensure that the appellant receives reimbursement for her premiums paid in October. HSRI is to rescind any additional premium bills, and resulting APTC considerations, which were incurred during the months from October through December 2014.

A handwritten signature in black ink, appearing to read 'Karen Walsh', written in a cursive style.

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.

4.6 **Special Enrollment Periods.** The Exchange shall provide special enrollment periods lasting a minimum of sixty (60) days and consistent with 45 C.F.R. §155.420 during which qualified individuals may enroll in Qualified Health Plans and enrollees may change Qualified Health Plans.

(a) *Triggering Events.* The Exchange will allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from one QHP to another if one of the triggering events defined in 45 C.F.R. §155.420(d) occurs. The Exchange shall also have the authority to define other triggering events not otherwise specified in 45 C.F.R. §155.520(d).

(b) *Effective Dates*

(1) *General.* Except as specified in §4.6(b)(2) of these Regulations, the Exchange shall establish a monthly deadline by which a qualified individual enrolling during a Special Enrollment Period must select a QHP and the Exchange must receive the first month's premium in order to make coverage effective on the first day of the following month. The Exchange shall make coverage effective on the first day of the second following month for a qualified individual not meeting the monthly deadline.

(2) *Special Effective Dates.*

- i. In the case of birth, adoption, or placement for adoption, the Exchange must ensure that coverage is effective on the date of the birth, adoption, or placement for adoption.
- ii. In the case of marriage or in the case where a qualified individual or dependent loses minimum essential coverage, the Exchange must ensure coverage is effective on the first day of the following month.

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.