Rhode Island Executive Office of Health and Human Services
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May 27, 2015

Docket # 15-223
Hearing Date: April 30, 2015

[redacted]

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:

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 4.4 Annual Open Enrollment Period
SECTION 4.5 Annual Open Enrollment Period Coverage Effective Dates.
SECTION 9.0 Agreements with Issuers

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 be allowed retroactive enrollment in his former dental coverage plan beginning on January 1, 2015.

RIHBE RULES AND REGULATIONS:
Please see the attached APPENDIX for pertinent excerpts from the Rules and Regulations Pertaining to the Rhode Island Health Benefits Exchange

APPEAL RIGHTS:
Please see attached NOTICE OF APPELLATE RIGHTS at the end of this decision.

DISCUSSION OF THE EVIDENCE:

The Health Source Rhode Island (HSRI) representative testified:

- We understand the difficulties involved with his (the appellant's) enrollment, but there's no HSRI policy in question here.
- The appellant did make a mistake in signing up for his plan, and we did reach out to his former carrier-Blue Cross, on his behalf, to see if they would grant retroactive coverage-which they would not.
- This is the carrier's policy, not the HSRI policy, and they make the decisions such as this and we are beholden to their decision.
- If there had been extenuating circumstances such as misinformation by either the carrier or our agency, there might have been a different outcome. This was not the case here.
- Because there were new carriers entering the RI market, we (HSRI) chose to re-enroll every customer at the end of the 2014 year for the 2015 year so our customers could shop around.
- Notices went out sometime in November (2014) prior to the beginning of open enrollment.
- The customer service representatives are expected to help you enroll in the same plan, or help you get a needed service if they are aware that there is a specific issue.

The appellant testified:

- He did receive the November 5th (2014) open enrollment notice, and became aware of the renewal process at that time.
- He attempted to re-enroll, and it would have been a better option to simply renew the plan that he was already receiving, just as his health plans in the past had always done.
- As a result of his prior experience, he never had to do this, and the plan he had was no longer being offered.
- He attempted to contact HSRI at least two times in the month of December trying to get some help, and he was able to discuss the situation, but got no clarity.

- He also had some difficulty understanding the accents of the representatives, so he went on line, and researched himself.

- He found as similar a plan as he could, and did not notice he was changing carriers, and chose a plan which was a good fit based upon the price and the coverage.

- He did not notice it would cost him another 12 months of premiums before he could get the coverage that he needed for the dental services he required.

- He wonders if the insurance companies do this so the carriers don't have to cover as many people for as many services.

- It was certainly an error on his part, but he would have preferred more effective assistance from HSRI and as a result of that lacking, he overlooked the issue.

- He overlooked the issue of informing the representative that he had already paid into the plan for eleven months towards his dental coverage; and, did not specifically inform the customer representative, as this was not how the process had worked in the past.

FINDINGS OF FACT:

- A November 5, 2014 annual open enrollment notice informed the appellant of the need for re-enrollment prior to January 1, 2015.

- A December 16, 2014 notice informed the appellant of his successful health coverage beginning on January 1, 2015, and informed him of his Delta Dental coverage effective on January 1, 2015.

- The appellant filed a timely appeal on January 16, 2015.

- A hearing was held on April 30, 2015.

CONCLUSION:

The issue to be decided is whether the appellant should be allowed retroactive enrollment in his former dental coverage plan beginning on January 1, 2015.

The appellant re-enrolled for dental and health coverages during open enrollment in 2014, allowing an effective coverage date beginning on January 1, 2015. The appellant had previously received dental coverage through the carrier Blue Cross Dental Direct. He had also previously paid premiums for eleven of the needed twelve months required towards a waiting period which would allow him to obtain specific dental services. That

Blue Cross plan was not available for 2015, and the appellant inadvertently chose a different carrier when choosing a comparable dental plan for 2015. As a result, he is responsible for an additional twelve months of premiums, as required by the new carrier, in order to be eligible for the desired dental work.

There is no dispute that the appellant himself chose the plan; and there is no dispute that the new carrier requires a similar waiting period of twelve months in order to obtain the dental services the appellant seeks. There is no dispute that the appellant was required to re-enroll due to HSRI policy, and that the specific dental plan offered in 2014 was not available in 2015.

The appellant argues that HSRI forced a re-enrollment process for health insurance coverage with which he was unfamiliar. Past experience with health insurances allowed the appellant to continue the same coverage annually, sometimes with a change only in premiums. In November 2014, during open enrollment he became aware that he must choose new coverage. The appellant attempted to choose the same plan, but was unable, as it was not offered. He spoke with HSRI on two occasions, but he cited that due to a lack of clarity about the plans, he chose to research on line, and then chose a dental plan himself. He testified that he inadvertently chose a plan under a different carrier. As a result, the appellant must pay premiums to the new carrier for another twelve months in order to obtain the dental procedure for which he had previously paid. The Agency agrees that HSRI had chosen to re-enroll health coverage recipients rather than allow continuation of policies, and this has caused some difficulties for enrollees. He argues that despite the difficulties for some, the re-enrollment resulted in more options for others. By allowing new carriers to enter the RI Market, the re-enrollment process then allowed the customers to choose amongst the new offerings, which in turn allowed additional coverage choices. The Agency further contends that the November 5, 2014 Annual Open Enrollment Notice notified the appellant of the upcoming renewal process. He testified that after being made aware of the appellant's grievance, the Agency did reach out to the former carrier-Blue Cross, to determine if they would accept the appellant retroactively into their plan and allow continuation of his premium payments toward the 12 month continuous coverage. He identified that Blue Cross would not grant retroactive coverage. The Agency further testified that HSRI does not interfere with the carrier's policies, and they are "beholden" to their decision. He contends that there is no policy issue in dispute. The HSRI representative allowed that the customer representatives are expected to assist with enrollment, and if the appellant had identified the specific issue of a waiting period, the representative should have helped the appellant address that issue. The appellant agreed that he had "overlooked" that issue when speaking with the representative. He testified that there was certainly error on his part, but felt that due to a lack of "more effective" assistance on the part of the customer representative the outcome was not favorable.

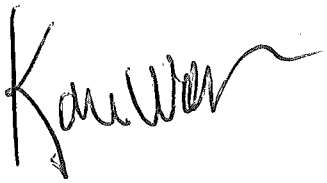
Exploration of HSRI regulations identify that the Exchange (HSRI) does establish a certification process for all their QHP Issuers. The Exchange negotiates, on an annual basis, these agreements with regards to product and/or service offerings. Additionally, the agreements are formed in advance of the Annual Open Enrollment Period for the

upcoming year. Per regulations, the Qualified Health Plan (QHP) offerings may vary from year to year.

Thus, at the time of the annual enrollment HSRI had already negotiated the plans with the carriers, and they were presented to the applicants on line. HSRI did make an attempt to negotiate for the appellant, but had no authority to negotiate a change in the plan already negotiated prior to the presentation of the plans which took place during open enrollment. The health source customer representative reached by phone did have an obligation to assist the appellant with regards to the numerous plans, and the premiums, and the coverage issues. The appellant testified that he finally chose a plan himself, which was a good fit for him with regards to coverage and premiums. Despite his difficulties in obtaining clarity about the programs, when considering his options with the HSRI customer representative, the appellant did not present to her, his overriding consideration for dental coverage-the twelve month waiting period. Despite the appellant's testimony that "more effective" assistance would have resulted in a different outcome, this assertion is doubtful, as the appellant obtained coverage that was a "good fit", and the representative would not have been addressing the waiting period issue because the appellant never mentioned that issue to her.

In summary, the appellant signed up for health coverage during a re-enrollment period offered in November. He had previously paid Blue Cross eleven months of premiums towards a waiting period for a dental procedure. He inadvertently chose a different dental carrier whose waiting period was also twelve months, meaning the appellant would now have to pay another twelve months of premiums to obtain the needed services. HSRI attempted to advocate for the appellant, but the insurance carrier is the arbitrator of the policy itself, and they chose not to allow retroactive coverage. As a result, HSRI, per policy, was unsuccessful in assisting the appellant, and he will be unable to retroactively be reinstated to coverage in the former plan.

After a careful review of the Agency's regulations, as well as the testimony presented, 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.

4.4 **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 9.0 AGREEMENTS WITH ISSUERS

9.1 **In General.** The Exchange shall establish a certification process for all participating QHP Issuers.

9.2 **Issuer Agreements.** All QHP Issuers must enter an Issuer Agreement with the Exchange describing the issuer's obligations with regard to offering products and/or services on the Exchange.

(a) Issuer Agreements shall be negotiated on an annual basis and formed in advance of the Annual Open Enrollment Period for the upcoming benefit year.

(b) QHPs offered through the Exchange pursuant to an Issuer Agreement may vary from year to 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.