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

May 14, 2015

Docket # 15-346
Hearing Date: March 31, 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

SECTION: 12.0 EXCHANGE TRUST PAYMENTS

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 Agency representative Noah Zimmerman.

ISSUE: Should the appellant have to pay any medical premiums owed between December 2014 and April 1, 2015?

Please see the attached APPENDIX for pertinent excerpts from the:
RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTHBENEFITS EXCHANGE (RIHBE)

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

DISCUSSION OF THE EVIDENCE:

The Agency representative testified:

- We acknowledge from listening to the call made on November 22, 2014 (to HSRI) that the appellant confirmed a plan for December 1st.
- A customer service representative did misinform her of the payment deadline.
- She (appellant) made her first payment on January 23rd, but we incorrectly applied that towards December.
- As a result she has been paying for coverage that she has not been able to use the benefits for.
- We think there were additional payments which I can submit at a later time.
- As of this moment, it appears that she is now listed in a Neighborhood Value Plan with an effective start date of April 1, 2015 in our computer system.
- From my understanding, that is what she was looking for.
- I will need to go back to the office and confirm that this is correct and it will be active.
- We can't tell how many times she has paid as of today, but we would simply credit the account going forward with those payments.
- We would need to rectify the tax credits in December as well, and no tax credits were assigned for 2015.
- We would like to review the billing information through HSRI.
- With regards to the HSRI errors, she should not be held responsible. She should obtain an exemption from penalty by the government, which she would need to apply for.
- The Agency is still attempting to rectify this.

The appellant testified:

- She called HSRI on November 22nd (2014) to sign up for December 1st coverage.
- Her former coverage through her employer ended on November 30th.
- She picked the plan, and asked repeatedly when the payment was due, but was given incorrect information as the representative said it was due on December 23rd rather than the next day which was November 23rd.
- As a result, the payment was not made in November, resulting in not being enrolled for insurance, and never receiving any coverage. She never received insurance.
- She called HSRI in late December and discovered that her initial payment was actually due on November 23rd, so she had no coverage. She then wanted to "re signup" for January 2015, but agreed to February 1st coverage.
- She asked to just start again because she never had insurance, and had never paid for the December insurance, and the HSRI representative agreed to start fresh.
- She chose a different plan and agreed to a February 1, 2014 start date.
- On January 22nd HSRI told her she was showing as still owing for December and she would need to file an appeal in order to have that wiped out. She was told to state that she was appealing her December coverage and that she wanted the new payment to be put towards her February coverage.
- She made a payment of $269.27 for the new plan on January 23rd now for coverage to begin on February 1st (2015).
- Coverage did not go through and on line there was no indication that it was confirmed, or effective, and she received no cards, or calls.
- By February 10th, she made a second payment of $269.27 for March to make sure that it was early enough for coverage.
- She still did not seem to have coverage and payments did not appear to be applied correctly.
- On February 23rd she went to a Navigator at Wood River Health Services to determine what was wrong. Together, they called HSRI and Marissa said she was sending the case to escalation. She told her to call back in 15 days to make sure it went through.

- On March 16th she went into the health center and she and the Navigator called HSRI again, and Stephanie of HSRI said it went to escalation but nothing had gone through and the representative was trying to figure out what the holdup was. She suggested attending hearing just in case it was not rectified.

- The full payment history which she is submitting no longer shows on line.

- The history invoice shows a payment on February 10th, and a payment on January 23rd.

- The January 29, 2015 invoice shows that there is a request for payment of $605.24. This is showing a December past due of $66.70(the difference between 1.23 payment of $269.27 and Dec. balance of $335.97 plus the amount now due for February and March @ $269.27each. It appears they did not bill for January.

- The March notice still shows she is not enrolled in a plan.

- She has not seen the April notice yet on line which shows that she has coverage.

FINDINGS OF FACT:

- The appellant received a closure notice from HSRI dated 12/30/2014 which indicated that as of 12/31/14 she would be losing her coverage, the reason being-"other".

- The appellant filed a timely appeal on January 23, 2015 appealing the statement that she would be losing coverage, as she had never had coverage.

- HSRI invoice notices show two payments of $269.27-one on January 23, 2015 for the month of February; and, one on February 10th for the month of March. The March 26, 2015 invoice shows an adjustment of $269.27 for months unknown and a charge of $335.97 due by April 23rd, most likely for the month of May.

- A March 3, 2015 notice identifies that the appellant is eligible for coverage beginning on April 1, 2015 but has not picked a plan.

- A March 30, 2015 notice indicates the appellant is eligible for coverage but has not completed enrollment. It later identifies she has selected a plan but must pay her first months coverage by the 23rd of this month, to become active next month.

- The appellant, as of the hearing on March 31, had not had medical coverage or received any coverage cards.

- A hearing was held on March 31, 2015.

- Per the appellant's request, the record of hearing was held open until April 21, 2014 for any additional evidence, and possible reconciliation discussions between HSRI and the appellant.

- Additional evidence was submitted by the appellant prior to the close of hearing.

CONCLUSION:

The issue to be decided is whether the appellant should have to pay any medical premiums owed between December 2014 and April 1, 2015?

There is no dispute that the appellant attempted to sign up for health coverage on November 22, 2014 during open enrollment. There is no dispute that coverage was scheduled to begin on December 1st, and that she chose a plan when enrolling. There is no dispute that the HSRI representative mistakenly informed the appellant that she did not have to pay her first premium payment until December 23rd.

RIHBE regulations clearly identify that 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. The notices and the bills generated by HSRI indicate that those payments dates are the 23rd of any given month in order to have coverage the following month.

The appellant testified that she went to HSRI on November 22, 2014 to sign up for coverage beginning on December 1, 2014. She picked a coverage plan, and asked the representative if the first bill was owed the next day-November 23rd, or December 23rd.The representative mistakenly told her the due date was December. As a result, per policy, the appellant was not enrolled for coverage without receipt of the first payment. When she did not receive a bill in December she contacted the Agency again and was told that she never had coverage because she did not make her initial payment. On January 22, 2015 the appellant spoke with the Agency and was told that she continued to show a payment owed for December, and the only way she could rectify the situation was to file an appeal which she did. She then signed up for a new plan, and paid her first months' premium of $269.27 on January 23 to begin coverage on February 1. She received no health cards, nor notices, nor any coverage information, and coverage did not go through on line. On February 10th, she paid her second premium of $269.27 early for the month of March coverage. She then went into a health center on February 23rd for assistance from a Navigator. HSRI was contacted and the representative informed the appellant that her case would be sent to "escalation" to be resolved as she still did not have coverage. She suggested calling back in two weeks. On March 16th she returned to the health center, and was informed through contact with HSRI that nothing had gone through and the representative did not know what the hold-up was. A March 3 notice identified that the appellant was eligible for an April 1, 2015 effective coverage date, but had not yet picked a plan. The appellant chose a plan on January 22nd. The March 30th notice indicated that the appellant had selected a plan but

must pay her first months' coverage. The appellant had already made a January 23rd and a February 10th premium payment and to date had no coverage. As of the date of the hearing the appellant had no health coverage. The appellant submitted a bill history which indicated that HSRI had made some adjustments on the bills for April and May, but continued to bill the appellant for December.

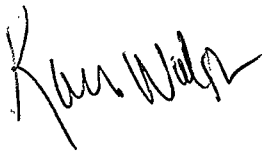
The Agency representative did not dispute the testimony of the appellant. He concurred that the representative gave initial wrong payment information which in turn prevented her from being signed up for coverage. He identified that the appellant's January payment had then been incorrectly applied to the December premium, although she had never had coverage in December. Further exploration of policy indicates that remittance of premium payments will be applied against towards the oldest premium payment showing open. Thus the January payment of $269.27 was credited towards the December payment of $335.97. He added that his records were indicating (on March 31) that the appellant was active for coverage beginning on April 1st. Post hearing, on April 10th, the appellant submitted evidence and wrote that HSRI was "still not correctly applying" her payments, and continued to show a balance due "for the insurance that is still not active as of" April 10th. At hearing the Agency indicated that in the event he could confirm the start date of April 1st, the Agency would have to credit the appellant's account going forward. He indicated as well that she would not be held responsible for any December tax credits, nor would she be penalized for a lack of insurance for the months of January through March or April, as this was an Agency error. He informed the appellant she must apply for an exemption to obtain the pardon.

In summary, the appellant attempted to sign up for health coverage in November of 2014 for coverage which was to begin on December 1st. Due to erroneous information from HSRI she did not pay in time, and was never enrolled in coverage. Regardless, the Agency applied her January payment (paid for February coverage) towards the December bill. The appellant made a second payment in February for March coverage. The appellant made two payments of $269.27 for coverage, which as of April 10, 2015 had not begun. Additionally, HSRI informed the appellant that as of February 10th her case had been sent to "escalation" in order for a speedy reconciliation-which never occurred. The appellant gave credible and undisputed testimony that she had been wronged by the Agency. The Agency is in agreement and concluded that the appellant should rightfully have her account credited going forward upon determination that she is receiving coverage. That determination had not been established at the time of the hearing. The appellant is not responsible for payment of any medical premiums incurred from December 2014 through March 2015. She is not responsible for a premium in the month of April if she did not receive any coverage, as indicated by the Agency at hearing, but not confirmed as requested, post hearing.

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 upon confirmation of medical coverage, the appellant will have her premiums credited towards her first two months of coverage. HSRI is to rescind any former bills and to rescind any APTC amounts associated with the months of December through March. It is unclear if the appellant has begun coverage as of April.



Karen Walsh
Appeals Officer

APPENDIX

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

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.

4.5 **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 12.0 EXCHANGE TRUST PAYMENTS

12.1 **Establishment of Trust.** The Exchange shall establish the Trust for the following purposes:
(a) Collecting health and dental insurance premium payments from qualified employers and qualified individuals;
(b) Remitting premium payments to QHP issuers on behalf of enrollees who participate in QHPs offered through the Exchange;
(c) Performing functions ancillary to the collection and payment of premiums to qualified health plan issuers and the receipt of payments for such products and services as may be offered through the Exchange; and
(d) Carrying out any other functions that are reasonably necessary in furtherance of the foregoing and in accordance with the establishment and maintenance of the Trust.

12.2 **Payments to the Trust.** Qualified individuals and qualified employers may remit premium payments to the Exchange to maintain participation in a QHP in accordance with all requirements under the Act and the Federal Regulations.
(a) Premium payments may be made in advance of the coverage month to which the payment applies.
(b) The monthly premium payment deadline shall be established by the Exchange.
(c) Premium payments will be applied against open premium lines in chronological order, beginning with the oldest outstanding premium payment.
(d) Payments may be received by the Trust from qualified individuals and employers for such products and services as may be offered through the Exchange.

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.