Rhode Island Executive Office of Health and Human Services
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May 19, 2015

Docket # 15-500
Hearing Date: April 16, 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

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: 1-Should the appellant have received health coverage for the month of December 2014?

2-Shoud the appellant be eligible for 2015 coverage as of February 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:

- Regarding timeliness-we do not dispute the time line, as the appellant called on Nov. 10 to re-enroll for 2015, but was dis-enrolled instead. At that time, the case was submitted to Priority team. She called again on December 3 to see what was happening as her case was to be sent 3 weeks earlier to the Priority team. We do not dispute that she did make another call on December 10th and may have followed that with an appeal on December 11, 2014.

- We are not contesting any claims made by the appellant.

- There was a mistake on her part during the enrollment process and our plan was to help get her re-enrolled for 2014.

- There were some issues in terms of tax credit eligibility, but we have been working to correct them.

- On November 10th, she first called to try and renew early for 2015.

- Whatever changes were made, she was dis-enrolled, but reported that on the November 10, 2014 call.

- She re-submitted her existing 2014 application to continue to the end of December in 2014.

- She was advised by customer service on November 10th that the issue was being sent to the Priority team to back out the changes that she made in November, and restore her coverage as well as her daughter's coverage for Medicaid (through February 2015).

- Her coverage was to be restored through 2014, and then she would need to re-enroll for 2015.

- The Feb.28, 2015 is the end coverage for the daughter's Medicaid prior to recertification.

- They (HSRI) also accepted a plan payment of the December premium, and we believe she was up to date at that time.

- There was a cancelled recurring payment to avoid withdrawals of an incorrect premium amount resulting from a billing issue at HSRI.

- December 3rd, she called to see what was happening in the last three weeks since her case was to have been sent to the Priority team.

- She called on December 31, 2014 to find out the status, and the result is unknown.

- She chatted with HSRI on January 3, 2015 and her daughter was covered, but appellant was dissatisfied about the expected new premiums.

- There had been an increase in January from around $44.00 up to $435.

- We did agree to remove a $435 bill from her account later on, because she should have still been billed $44 for December. She should have received a tax credit for December also.

- We have already agreed to remove the balance, and she already paid the premium for December, but we tried to take more than we were entitled to.

- Currently, we have updated our own system so she is backdated to January 1, 2015.

- Blue Cross indicated she had a starting date of February 1, 2015.

- After hearing her issue of coverage sign up in January for February, we are in agreement to back date to February instead of January.

- We are in agreement that the second appeal is combined with this one, as she was disputing a coverage starting of March 1, 2015, rather than in January or February.

- The issue is that there is a glitch with the BlueCross system and they identified she had a starting date of February 1, 2015.

- We are actively working within two systems, and we are working on the billing issue.

- HSRI is showing she is covered for the current months, and she would need to re-submit the claims and they will be paid. We are recommending she continue to use her coverage, and we are working to rectify this.

- The Agency is still attempting to rectify this.

The appellant testified:

- Regarding timeliness-she filed an appeal form on December 11 after several conversations with HSRI. She faxed her original paper appeal, and marked the fax date, as is her habit in the right hand corner-Dec.11, 2014. She was disputing that that she started making phone calls on Nov 10/Nov 11, as soon as she was accidentally dis-enrolled in November for 2015. Her case was to have been sent to the Priority team and would take about 15 days. But at the 2nd call on Dec. 3rd-the system was down and the representative could not tell if resolution was reached. She called again on the same day, and was told that Priority team was able to open her account and had received her information. She faxed her appeal that next day. The appeal form was from the back of an 11.14.14 notice which is the notice she was appealing. A second appeal in March is a continuation of the same issue but it identified a beginning coverage date of March 1, 2014.

- She was allowed to enroll, but the system does accept the premium, but does not give her coverage.

- She has gone to only some appointments, as she was told initially she was to pay out of pocket, but she could not keep doing this.

- She obtained the phone log from HSRI which shows a time log beginning in November.

- She is looking for removal of the $435, and wants coverage to begin on February 1st.

- For months she has been told that this would be resolved, but it's not resolved and she keeps hearing more of the same.

- She did not pay a January premium because she was told when she made the call on January 6th to finally sign up for 2015 that coverage would start on February and she was fine with that, so she paid the February premium.

- She paid for February, March, and April. She did not pay for January because she was not covered.

- She filed a second appeal because she was told her insurance was to begin March 1, 2015, and she has already paid for, and used her insurance in February.

FINDINGS OF FACT:

- On November 10, 2014, the appellant attempted to sign up early for January 2015 coverage. She inadvertently was dis-enrolled from the system and her current 2014 coverage was terminated.

- A history of phone calls with HSRI indicates the appellant first called on November 10th to HSRI, was told to resubmit the November 2014 information, was informed that issues were being submitted to the Priority Team to back out changes and restore QHP. The document shows that a December payment was accepted, and the electronic recurrent payment withdrawals were cancelled to "safeguard against deduction for incorrect premium amount of $397.27.

- A November 14, 2014 eligibility notice indicated that the appellant had not yet signed up for coverage and was eligible for a special enrollment, and further indicated her tax credit amount.

- The appellant contacted HSRI for update on December 3 and December 10, 2014 for updates from HSRI.

- The appellant states she filed an appeal on December 11, 2014 which was not received by HSRI/EOHHS.

- The appellant received a February 17, 2015 notice indicating her new coverage would begin on March 1, 2015.

- The appellant filed an appeal on February 24th indicating a continuance of issues begun in November, and disputing March 1st starting date for 2015 coverage.

CONCLUSION:

The first issue to be decided is whether the appellant's appeal is timely. An Agency notice dated November 14, 2014 informed the appellant of her lack of existing coverage. The appellant identified that she appealed the notice, but never received a response. She testified that she contacted the Agency on December 10th, and then filed immediately following-on December 11th. On the complaint the appellant indicated that she had been waiting for four weeks to hear from the Agency- a time frame corroborated by the Agency in that she had first called HSRI on November 10th. The statement of complaint would indicate that the time was around December 10th/or 11th in reference to the four week time frame, which is the date she testified she sent the appeal. The appellant provided further evidence that she had been told her case was sent to the Priority team on November 10th, and upon discovering in early December that this did not happen, she filed the appeal. The appeal form was also dated

November 14th as it was removed from the back of the November 14th notice being appealed. The appellant noted that she had marked in the upper right corner the fax date and information as was her habit. It showed a date of December 11th. The appellant gave credible evidence and testimony that she was proactive in trying to sign up early for health coverage (November 2014 for 2015 coverage), that she contacted HSRI immediately following a glitch in the system-same day, and that she followed up repeatedly prior to her formal appeal. She had also documented a fax date on the document which coordinated with the time frames acceptable for this appeal. Due to the credible and consistent reasoning, the request is considered timely.

The appellant filed a second and timely appeal on February 24, 2015. The two appeals were combined for this hearing, as the second appeal notes a continuation of the same issues as a result of the initial November dis-enrollment and the subsequent missteps.

The two fundamental issues to be decided are whether the appellant should have received health coverage for the month of December 2014; and, whether the appellant should have a coverage starting date of February 1, 2015 for the 2015 coverage for which she applied.

There is no dispute that the appellant attempted to sign up for health coverage on November 10, 2014 for the 2015 renewal. She was inadvertently dis-enrolled from her 2014 ongoing coverage, and contacted Health Source Rhode Island (HSRI) on that same day to rectify the deletion. There is no dispute as well that she was informed that her issue would be submitted to the Priority team immediately. There is no argument that HSRI then accepted a December payment of $44.71 noting that the incorrect premium of $397.27 had been billed. There is no dispute that in January the client had an erroneous balance of $435.56 but had never purchased or chosen a plan for 2015 due to her ongoing issues. There is no dispute that on January 5, she asked again for the initial issues to be cleared, she chose a plan, and was enrolled for 2015 with a stated starting date of February 1, 2015. There is no dispute that the appellant contacted HSRI on January 20 to request to make a payment to begin her new coverage for 2015. She remitted $111.59 as requested. There is no dispute that the appellant received a February 17th notice indicating that her 2015 coverage starting date would be March 1, 2015.

There are no disputes whatsoever between the appellant and the Agency, except the lack of corrections and the inability of the Agency to rectify the situation for the appellant. The Agency agreed that the appellant should have the removal of a $435 bill placed on her account in January, and that she should receive a tax credit for December which was not forthcoming. The Agency identified that there was a glitch between the two systems-HSRI and Blue Cross, and they were attempting to reconcile this. They acknowledged that Blue Cross showed a starting date of February 1, and that payment and sign up in January would have allowed a February 1 starting date. Thus, they do not dispute this, although the representative initially identified his understanding that the Agency thought that January 1 was the beginning date. The appellant indicated that she had, at the time of the hearing, paid for February, March, and April. She had

never paid for January due to the unresolved issues, and was told that coverage began on February 1. She testified that she was fine with that.

Notes obtained from HSRI and submitted into evidence by the appellant indicate that as of April 10, 2015 Blue Cross continues to indicate that the appellant is not active at this time, and HSRI notes indicate that they consider the start date for the appellant to be January 1, 2015. Previous notes obtained from January 5th conversations with HSRI indicate that HSRI at that time informed the appellant of a February 1 eligibility date. Evidence supports that the appellant paid her first 2015 premium on January 20th. Current notes further indicate that both systems are attempting to rectify back to January 1. The Agency identified that the appellant should use coverage as this should be retroactively corrected.

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.Thus, if the appellant paid on January 20th as indicated by the HSRI notes, she was paying for the month of February, and is not responsible for January premiums despite the possibility that coverage may be rectified back to that date.

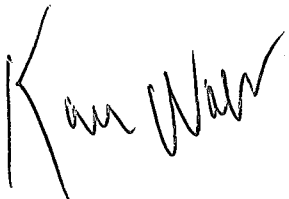
In summary, the appellant attempted to sign up for health coverage in November of 2014 for coverage for 2015 as she was already covered until the end of 2014. While attempting to sign up, she was inadvertently dis-enrolled from her 2014 coverage. She contacted HSRI immediately, and they began to reconcile the issue by sending the case to their Priority team on November 10, 2014. To date, there has been no resolution, which in turn has confounded the appellant's ability to sign up for coverage in 2015. She did this in January expecting a starting coverage date of February 1st, as evidenced by the HSRI notes, and the initial Blue Cross findings. To date, the appellant has not been covered for December 2014, was erroneously billed $435.56 in January, was not given her APTC's in December, and was not enrolled in 2015 coverage for which she paid beginning in the month of February. The appellant has paid for February, March, and April 2015. The appellant and the Agency are in agreement that reconciliation is needed.

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 amount of $435.56 is removed from the appellant's bill. They are to rectify the December APTC's omitted from her notice and ensure coverage for

the month of December. They are to ensure that she has the coverage retroactively to February 1, 2015 and ongoing, for which she has already paid February through 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.

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.