



Rhode Island Executive Office of Health and Human Services  
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October 25, 2016

Docket # 16-2461  
Hearing Date: September 29, 2016



## **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 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: Lindsay Lang, Esq., Ben Gagliardi, Esq., and Derek Tevyaw.

Present at the hearing were: You (the Appellant), and HSRI representative Ben Gagliardi.

**ISSUE: Should the appellant's Blue Cross/Blue Shield health coverage have terminated as of June 30, 2016?**

#### **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:**

- She (appellant) enrolled in health coverage with her husband through HSRI on or about May 20, 2016 with a June 1<sup>st</sup> start date.
- She was enrolled in that coverage up until August 31<sup>st</sup>.
- HSRI did receive a phone call on August 9<sup>th</sup> in which she (the appellant) stated that she was calling about Invoices she was receiving, and that she had wanted her coverage to continue through the month of June only. She did not dis-enroll after June because she alleged that customer service told her she did not need to call to dis-enroll.
- Voluntary terminations requested during the month will result in termination on the last day of that month, in this case the call was in August.
- If that month is already started, then payment was already due on the 23<sup>rd</sup> of that month before that.
- Based on the prehearing conversation the appellant believed that she was informed on May 24<sup>th</sup> when she signed up that her coverage would remain effective for one month only.
- The Health Track notes from that day have been reviewed, and there is only one note that “customer called because they wanted to know what insurance they were in, and customer wanted to select a plan over the phone. Coverage begins on June 20, 2016.” It lists a payment transaction on May 20.
- She is saying she paid for June, and if that’s the case, although the call was not until August, as a matter of comity, her coverage actually would have retroactively ended on July 31<sup>st</sup> because of the allowance of a grace period when she did not pay, and the bill would have gone back to the 31<sup>st</sup>.
- She made a phone call around May 31<sup>st</sup> regarding her daughter’s coverage which was a different coverage through Medicaid, not through HSRI.
- We agree, that as of June 1<sup>st</sup>, she and her husband had Blue Cross coverage, and did not have United insurance or NHP, but their daughter was involved in other plans.
- She had active coverage with us beginning on June 1<sup>st</sup>, and there is no record of calls in which she indicates difficulty using the Blue Cross coverage, nor a record of June calls, although we will review the record for any June calls.

- In response to her difficulties with her coverage, the therapist would not have called us, they would have directed their call to the carrier; and, if she was not receiving her cards and called us we could have gotten Blue Cross on the line.
- In response to whether or not you received a card, it is the practice Blue Cross that they send both a card and an Enrollment packet when you enroll and that information is sent to the address of record.
- Her coverage was active through HSRI and cards generally arrive within 10 days, and if she had needed the cards and contacted HSRI, we could have assisted with a call to the carrier.
- Your provider determines what they will or will not accept for providers, and as to whether or not they will accept insurance prior to receipt of your card.
- We sent all our information to the address of record.

### **SUMMARY OF May 24<sup>th</sup> phone call with HSRI-**

The appellant contacted HSRI in order to pick her plan which she had reviewed in a prior call. During the call, the representative asked the appellant if she would like to close her coverage at the end of June, and have just four days uncovered as she believed her husband would be covered as of July 4<sup>th</sup>. The appellant responds, “No, leave it, leave it.” She adds her concern that the employer insurance may not start as planned-“God forbid, it could be different. I’ll call at the end of the month.” She states, “If I don’t make payment by June 23<sup>rd</sup>, I’m not going to have it anyways.” The representative does not respond as the appellant immediately begins to discuss other issues. The representative later informs the appellant she should call by the end of June to determine options for her daughter. The appellant reiterates-“Leave it in and at the end of the month I’ll take everything down, and when I know for sure that everything is going on the 4<sup>th</sup>, then I’ll cancel everything (she is speaking about both coverages). The representative tells her she can update then. The representative provides the phone numbers for the daughter’s carrier and the appellant’s separate carrier, and suggests she call prior to June 1 as a precautionary call to update the carrier and insure the primary care physician and to insure she is active. The appellant agrees she will do this immediately. The appellant asks, “I’m all set until the end of June?” In her final comment the appellant jokingly suggests calling the representative by the end of June and she’ll let him know if her daughter’s July 4<sup>th</sup> birthday party is still on.

### **The appellant testified:**

- When she called (HSRI) she was under the assumption that she would have the coverage for only thirty days, and that she only needed the coverage for thirty days.
- She was worried that her daughter, who gets the free insurance would be

affected and wanted to be in compliance with the insurance rules.

- She knew that her whole family would be under her husband's plan as of July 4<sup>th</sup>, but it turned out it was July 2<sup>nd</sup>.
- Whoever she spoke to, she did ask what she needed to do and what would happen if she just didn't pay the bill.
- She understood she'd automatically be terminated if she did not pay the bill.
- She would have called if she knew she had to, as she "lives by her calendar" and they had a tough year already, and she was embarrassed by the free care.
- She was getting Neighborhood cards and when she called to find out about them, she was not in the system under the NHP.
- When she tried to get therapy she was unable to use her United and NHP cards because she wasn't in the system.
- At one point she had somewhere around three coverages.
- Her husband had United Health insurance, and they all had NHP, and there was confusion about that insurance but it was discontinued but her daughter received United Health cards.
- She guesses she purchased a Blue Cross plan but no one could give her number at United Health although she was allowed a prescription which went through, but she does not know what insurance they applied it to.
- She did have an Anchor card (Medicaid) which was related to her daughter's account, and she could not use that and she had a three way conversation with United Health.
- She did pick the Blue Cross plan and knew she had it during those thirty days but she feels she could not use the plan.
- She did call DHS and United Health and her husband's past employer, but no one could help her.
- She also called HSRI within May and the following week to try and get information so she and her daughter could use her coverage, but they could not help her.
- She never received any cards up until this day, and the therapist refused to see her without the card.

- The carrier showed she was not active, and she couldn't get the information.
- Also, the cards could have gotten sent to the wrong address, and not to the PO Box which is another mistake.
- Yes, she could explore the Blue Cross calls and whether they told her she did not have coverage when HSRI said she did.
- She paid for June on May 31<sup>st</sup>, and never paid for July.

**FINDINGS OF FACT:**

- The appellant contacted HSRI on or about May 20<sup>th</sup>, enrolled in a Blue Cross Coverage plan with an effective starting date of June 1, 2016, and paid for the plan.
- A QHP Enrollment notice was generated on May 24, 2016.
- The record shows no further contacts in the month of June with HSRI.
- The appellant contacted HSRI on August 9, 2016 noting that she had originally informed the Agency when signing up in May, that she had wanted coverage for the month of June only.
- An August 10, 2016 Notice of Eligibility was generated showing a July 31<sup>st</sup> coverage end date for the appellant and her husband, reason-“got other coverage.”
- The appellant timely appealed on August 11<sup>th</sup> disputing the end coverage date.
- A hearing was held on September 29, 2016.
- The record of hearing was held open for submission of additional evidence.
- Additional evidence was submitted.

**CONCLUSION:**

**The issue to be decided is whether the appellant's Blue Cross/Blue Shield coverage should have terminated as of June 30, 2016.**

There is no dispute that the appellant applied for and received medical coverage as of June 1, 2016, through the assistance of HSRI. There is no dispute that the appellant contacted HSRI again on August 9<sup>th</sup> to dispute the coverage end date. There is no

dispute that the August 10<sup>th</sup> notice indicated a retroactive closure date of July 31<sup>st</sup> for the reason-got other coverage.

Regulations specific to the RI Health Benefit Exchange (RIHBE) determine that upon a voluntary termination request submitted at least fourteen days prior to the end of the month, then coverage will terminate at the end of the month. Coverage shall terminate at the end of the following month if the termination request is submitted less than fourteen days prior to the end of that month. HSRI policy now waives the fourteen day requirement and allows a termination on the last day of the month in which it is requested.

The appellant argues that she did not make a June call to HSRI to terminate her coverage, as she had made the termination arrangements on the day she enrolled. She testified that at that time she had made the Agency aware that her husband's insurance would begin on July 4<sup>th</sup> and she did not want continued coverage. She noted as well that she was unaware she would owe for the following month as she understood she'd be automatically terminated if she did not pay the bill.

The Agency presented the voluntary termination policy by which the appellant's coverage should have been terminated at the end of August because the call was made by the appellant in August. They later noted that the 90 day grace period had also been in effect, so that the appellant was actually allowed continued coverage until her third month of non-payment in September, and was then retroactively terminated as of July 31<sup>st</sup>, so that she owed for the month of July only. The Agency presented a phone summary of the appellant's call to HSRI at enrollment which did not support the appellant's argument. To obtain clarification, a copy of the call was submitted post hearing.

A review of the call to HSRI reveals that the appellant did, in keeping with her testimony, address many of the issues she reported. She spoke about losing her coverage after non-payment, and about her husband's employer sponsored insurance, and about his coverage beginning date of July 4<sup>th</sup>. However, the overall inference of the call is that the appellant does not want to be without coverage for even the first four days of July, and she is not entirely sure the coverage for her husband will begin even then. When asked directly if she would like the representative to remove her coverage as of the 30<sup>th</sup> of June, she states, "No, no, leave it. He's (husband) saying one thing and God forbid, it could be different. I'll call at the end of the month." She further notes, but does not question, "If I don't make the payment by June 23rd, I'm not going to have it anyways." Although the appellant may see that as a question of payment responsibility, the statement and subsequent statements by her do not make that clear. Further, following that statement, the representative tells her to call at the end of June. She again tells the representative to leave everything and at the end of the month she'll take everything down, and "when I know for sure that everything is going on the 4<sup>th</sup>, I'll cancel everything." The appellant asks, "I'm all set until the end of June?" He answers in the affirmative, and again the discussion about a June phone call is presented. The appellant makes clear in the call that she does not want to be without coverage for even

one day. Thus, knowing at the time, she cannot have coverage until at least July 4<sup>th</sup>, the appellant, regardless of her understanding of payment, would have incurred the cost of the month of July. HSRI coverage begins at the beginning of the month and is not prorated. Thus, one day into July incurs billing for the entire month. Additionally, the appellant did not make clear at any time, that she was questioning the process, but made clear that she would call at the end of June, which she admittedly did not do. She called in August, but incurred payment for July only as the Agency allowed her the 90 day grace period regulations which resulted in a balance for one month only.

In addition to the coverage end date issue, the appellant addressed her inability to utilize the coverage she had, and her concerns about receipt of her information to the wrong address. Specifically, she did not receive her Blue Cross cards, and was told by one provider they would not see her without the cards. With respect to the address, the address of record was provided by the appellant. She clarified her address with this office prior to hearing, in that she added her PO Box to the address. Prior, the address of record included only her street address which was provided by her. She, is responsible for her address. The Agency noted that the appellant could have called HSRI for the actual cards in June, if the provider, as was his prerogative, chose not to allow service until receipt of the card. The Agency, post hearing, found no calls in June with which to support the appellant's recollection. Regardless, the absence of the cards does not affect the appellant's omission in cancelling her policy with HSRI at the end of June-the issue under appeal.

The appellant also testified to difficulties using her coverage. When told by the carrier she had no coverage she contacted HSRI. HSRI argues that she always had coverage, and that the phone records do not support any complaints to them of her difficulties using the coverage, or in obtaining her cards with which they could have assisted. The record supports some confusion on the part of the appellant which might have lent itself to her lack of ability to find the correct providers and to be found in the system by the providers. During testimony and during the phone call to HSRI, the appellant demonstrated confusion about which coverage she had. Understandably, the appellant identified four different coverages and two or more carriers during a three month period. She and her family had been on a Medicaid plan through one carrier until her daughter went on a separate plan after which she and her husband then changed to a Blue Cross plan which was to change to another carrier and plan on July 4<sup>th</sup>. During the first 10-20 minutes of her May enrollment call to HSRI she requested exploration of a United insurance plan, until realizing she was exploring the wrong plan and she meant to request Blue Cross-which she eventually chose. Likewise during testimony the appellant stated she could not be found in the system, but it was unclear what carrier she was presenting as she identified attempts to contact United for her coverage which was Blue Cross. Additionally, the record does not support a call to HSRI to clarify, though the appellant may have called Blue Cross. To that end, the Agency reviewed their records during held open and found no June calls, and, the appellant was allowed time to explore with Blue Cross as to whether they had informed her she did not have coverage in June. No additional evidence was sent to support her claim.

In summary, the appellant signed up for coverage in May 2016, and was aware at the time her husband would be obtaining coverage through his employer as of July 4<sup>th</sup>. She believed she had informed HSRI during enrollment that she wanted coverage to terminate on June 30<sup>th</sup>. In reviewing calls to HSRI the appellant actually represented that she did not want to go four days without coverage from June 30<sup>th</sup> to July 4<sup>th</sup>, and was not completely certain that the July 4<sup>th</sup> starting date was solid. She further represented that she would contact the Agency at the end of June to effect changes, and she did not. Regardless, the appellants' husband did not obtain employer sponsored coverage until after July 1<sup>st</sup>, and in order to have any coverage in July, which is what the appellant required, she would have had to pay for the entire month of July. Thus, the record does not support that the appellant requested termination until her August contact with HSRI, and that she required coverage as of July 1<sup>st</sup>. Consequently, the appellant is responsible for payment for the month of July as she was not eligible for a June 30<sup>th</sup> closure date. Although the appellant did not contact the Agency until August, she was allowed a July 31<sup>st</sup> end date due to regulations related to her tax credit receipt and the grace period allowed for closure.

After a careful review of the Agency's regulations and the testimony and evidence submitted, the Appeals Officer finds that the appellant's request for relief is denied. Her coverage did not end on June 30<sup>th</sup>, but correctly terminated, per policy, on July 31, 2016.

Karen Walsh  
Appeals Office

## APPENDIX

## **RULES AND REGULATIONS PERTAINING TO THE RHODE ISLAND HEALTH BENEFITS EXCHANGE**

### **7.8 Effective Date of Termination.**

#### *(a) 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.

#### *(b) 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.