STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. H-06/17-297
	)	
Appeal of	)	
	)	

INTRODUCTION

The petitioner appeals the decision by Vermont Health Connect ("VHC") terminating her health insurance coverage under a Qualified Health Plan (QHP) and denying her request for reinstatement. The issue is whether VHC's decision is consistent with its regulations.

The following facts are based on the representations of the parties at and the documents submitted pursuant to telephone hearings held on August 9 and 31, 2017.

FINDINGS OF FACT

1. The petitioner, who had been receiving Medicaid in 2016, was found ineligible for those benefits as of December 31, 2016, due to excess income. However, VHC offered the petitioner enrollment in a QHP based on her loss of Medicaid (her "Minimum Essential Coverage" [MEC]).

2. On January 9, 2017, the petitioner was found eligible for a QHP subsidy based on her income, and the plan

she chose required her to pay a premium of $55.45 per month as her share. The petitioner was advised that her coverage would not go into effect until she paid that first premium for January of 2017.

3. On January 11, 2017, the petitioner requested that the coverage be made retroactive to January 1, 2017 as she needed to pick up medications as soon as possible.

4. On January 12, 2017, the petitioner paid her first premium to VHC, which was then transmitted to Blue Cross Blue Shield (BC/BS), her chosen carrier.

5. On January 16, 2017, VHC successfully changed the start date of the insurance to January 1, 2017.

6. On January 19, 2017, the petitioner called to find out when she would receive her enrollment cards and to confirm that the start date was January 1, 2017. The VHC worker advised her that the payment had been transmitted to BC/BS and that it usually took about five days to process. She told the petitioner that the enrollment cards should be reaching her any day, and that, as per the petitioner's request, the start date of the insurance had been "flipped" to January 1, 2017.

7. The petitioner was officially enrolled and able to access services as of January 20, 2017, with all bills to be covered retroactive to January 1, 2017.

8. VHC sent the petitioner an invoice on February 5, 2017 stating that she had an arrearage of $55.45 for February's insurance and now owed another $55.45 for March, for a total of $110.90. The invoice instructed her that her premium payments were due by 26th of the month, that they had to be paid in full, and would be considered late if not received by the end of the month. The petitioner made no payment in February of 2017.

9. On March 3, 2017, BCBS sent the petitioner a notice telling her that she was in a grace period because her account was past due. She was advised to pay the total amount on her current invoice by the end of the month or she would be placed into a 2nd month of grace. The entire process was explained in the notice, including the cut-off of benefits if she had failed to catch up with her back payments by the end of third month of her grace period and that she would not be allowed to re-enroll until January of 2018. She was advised to call the VHC Customer Service Line number on the notice if she had any questions.

10. On March 5, 2017, VHC sent the petitioner an invoice showing that $55.45 was due for April and that $110.90 was past due. Again, the invoice stated that these amounts had to be paid in full or would be considered over due after March 31, 2017.

11. The petitioner did not call VHC to question the invoice. She paid only $55.45 on March 18, 2017.

12. On April 5, 2017, the petitioner received an invoice for May of 2017 of $55.45, with an additional past due amount of $110.90. The invoice again stated that all these amounts needed to be paid in full by April 30, 2017.

13. On April 7, 2017, BCBS sent the petitioner a grace period notice identical to the one sent on March 3, 2017, except it advised the petitioner that she was in her second month of grace. Again, the notice informed her to pay the invoice amount for that month in full by the due date to avoid triggering a third and final grace month, and to call VHC if she had any questions.

14. The petitioner did not call VHC; instead she paid the current amount of $55.45 on April 17, 2017, and with regard to the $110.90 arrearage, she wrote on the coupon accompanying the payment: "I am not past due."

15. On May 3, 2017, BCBS sent the petitioner a grace period notice like the first two, but advising her that she was in her "third and final" month of grace period and that she needed to pay the entire amount of her current VHC invoice by May 31, 2017, or her insurance benefits would be terminated. Again, the notice advised her to call the VHC customer service line if she had questions.

16. On May 5, 2017, VHC sent the petitioner an invoice showing that she owed $55.45 for June 2017 and that she was still in arrears by $110.90.

17. The petitioner did not call VHC, but instead paid only the current amount of $55.45 on May 18, 2017.

18. On June 6, 2017, the petitioner discovered when she tried to pick up her medications that BC/BS would not cover her payments. She called the VHC Customer Service Line on that day to see what was happening. This was the first time she had called VHC since her initial enrollment call on January 19, 2017 (see *supra*).

19. The VHC worker who handled the call saw from looking at the records that the petitioner's case was still marked as "active." She had no information in her records about BCBS putting the petitioner in a grace period, and the petitioner did not advise her that this was the case. The

worker could see that the petitioner had failed to make the payments for February and June of 2017 by the due date and that she now also owed for July of 2017.[1] The worker (correctly) guessed that the loss of coverage reported by the petitioner was related to the petitioner's failure to pay the arrearages. The petitioner disputed that she owed a payment for February of 2017, saying that she had made that payment back in January, but the worker advised her that the January payment had been credited to the month of January, 2017, not February. The petitioner insisted that her coverage had actually begun February 1, not January 1, because she had been unable to access benefits in early January. The worker told her that this was incorrect, that she had been told she was covered as of January 1, 2017, and that she could submit any outstanding bills for that month to the insurer. The worker advised the petitioner that the best way to restore her insurance benefits would be to pay the outstanding balance of $166.35 as soon as possible and certainly no later than the end of the month to avoid possible termination. The petitioner still disagreed with the amount, stated that she

[1] The petitioner's failure to pay anything in February of 2017, had actually put her two months in arrears for February and March. This is why she consistently showed a two-month arrearage. Thus, the information the worker gave the petitioner, that two months were in arrearage and one month was currently due, was correct.

did not have the money to make the three payments, and that she would see what she could do and would be back in touch.

20. It turned out that BC/BS had terminated the petitioner's insurance that same day, June 6, 2017, which likely had caused the shut-off of the petitioner's pharmacy benefits. However, VHC did not learn of the termination until after its phone conversation with the petitioner. On June 9, 2017, BC/BS sent a termination letter to the petitioner notifying her that the termination of her coverage would be retroactive to March 31, 2017, due to her failure to pay her premiums within the 3-month grace period.[2]

21. On June 12, 2017, the petitioner called the VHC payment line to make a payment on her insurance but was unable to do so as her account was now marked as terminated and showed no balance owed.

22. It is found that all the invoices and grace period notices that the petitioner received were clear, timely, and accurate. The petitioner does not dispute that she received all the invoices and grace period notices described above. She admits that she didn't read them carefully, but she maintains that this was because she didn't think her payments

[2] The potential for retroactive loss of coverage had been explained in the grace period notices that BC/BS had previously sent to the petitioner.

were actually in arrears because she thought her coverage had not started until February.

23. However, it cannot be found either that VHC gave the petitioner any incorrect, confusing, or inaccurate information regarding the start date of her coverage (January 1, 2017), or that the petitioner had any other reasonable basis to believe (and certainly not to *continue* to believe) that she had not had (and was not liable to pay for) coverage effective January 1, 2017.[3]

ORDER

The decision of Vermont Health Connect is affirmed.

REASONS

The Board's review of VHC decisions is de novo. The petitioner appeals VHC decisions terminating her QHP coverage and not allowing her to be reinstated back to March 1, 2017. The petitioner has the burden of showing that VHC's decisions are contrary to its regulations. Fair Hearing Rule 1000.3(O)(4). Based on the above facts and the applicable

[3] Even if the petitioner, after her phone call to VHC on January 19, 2017, did have a reasonable basis to believe her coverage would not become effective until February 1, her failure to have made any premium payment in February would have still meant that she was continually one month behind in her payments, rather than the two month arrearage noted in her invoices, and the result in this matter would have been the same.

VHC regulations (*infra*) it must be concluded that the petitioner has not met that burden.

VHC's rules provide that individuals who are enrolled in a health insurance plan through VHC must pay a premium for each month of coverage under that plan. Health Benefits Eligibility and Enrollment Rules (HBEE) § 64.01(a). The amount due for each month must be paid in full in order for an enrollee to maintain coverage. HBEE § 64.05(a). Pursuant to the process for paying for plans offered on the Exchange, VHC bills enrollees and collects premium payments for insurers. HBEE § 64.04. When billing enrollees, VHC sends a monthly premium invoice by the 5th day of each month stating that the payment is due on or before the last day of the month for coverage for the following month. HBEE § 64.04(a)(1) and (2). If the premium payment is received or postmarked by the last day of the month, an enrollee's coverage continues into the next month. HBEE § 64.04(b) and (c).

If a premium is not timely and fully paid, the rules provide for a grace period of three consecutive months for enrollees, such as petitioner in this case, who receive federal Advanced Premium Tax Credit subsidies. HBEE §

64.06(1)(i).[4] In the event of nonpayment, the insurer has the obligation of providing grace period notices which meet certain minimum requirements. HBEE § 64.06(b)(1). If the enrollee's nonpayment is cured in full before the grace period has been exhausted, coverage continues. Conversely, if the premiums that accrued during the grace period are not received in full by the end of the three months, VHC must allow insurers to terminate coverage for non-payment of premiums. HBEE § 76.00(b)(2). The effective date of closure in such circumstances is the last day of the first month of the three-month grace period. HBEE § 76.00(d)(4).

There is a provision in the regulations for individuals enrolled in a QHP *without APTC* to have their coverage reinstated if they pay all past current and past due premiums within 30 days of a termination for nonpayment. However, there is no such provision applicable to individuals (like the petitioner) who *do* receive APTC.

VHC's records in this case clearly show that the petitioner received timely and accurate notices and that she was properly placed in a grace period for three consecutive months beginning in March 2017, and that the last date for

[4] Individuals not receiving a subsidy have a grace period of one (1) month. HBEE 64.06(a)(1)(ii).

full payment within that grace period was May 31, 2017. The record also shows that VHC gave the petitioner clear, accurate, and consistent information when she called on January 19, 2017 to inquire about her coverage. It further shows that by the time the petitioner again called VHC on June 6, 2017, it was too late for VHC to have helped her restore her coverage, even if the petitioner had been able to pay all the arrearages and the next month premium that she owed as of that day.[5]

Inasmuch as VHC's decisions allowing the insurer's termination of the petitioner's QHP coverage and denying her request for reinstatement are consistent with its regulations, the Board is bound to affirm. 3 V.S.A. § 3091(d); Fair Hearing Rule No. 1000.4D.

# # #

[5] Although it wouldn't have made a difference in this case in terms of the loss of the petitioner's coverage that had occurred as of May 31, 2017, the Board has previously stated that VHC should have a system and protocols in place that integrate all information regarding insureds' accounts between the VHC help and payment lines *and the insurer*, so that complete, accurate and timely information regarding an insured's payment history *and grace period status* is available to whichever VHC telephone number an insured might call for help and information.