STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. S-05/17-228
	)	
Appeal of	)	
	)	

INTRODUCTION

Petitioner appeals certain actions by the Department of Vermont Health Access ("Department") in administering the payment of premiums for her health insurance during 2017. The following facts are adduced from a telephone hearing held June 6, 2017, several telephone status conferences following the hearing, and documents submitted throughout the appeal process. The primary issue is whether petitioner's appeal is moot. A lengthy procedural history is incorporated into the facts.

FINDINGS OF FACT

1. Petitioner filed this appeal in May of 2017. Her appeal stemmed from being informed in March of 2017 that she could become current, through April 2017, on her then-owed 2017 insurance premiums by paying a total amount of $1164.20.

2. However, after making that payment, petitioner learned that VHC had applied a portion of the payment to an arrearage from December 2016 (of $409.49), leaving her (from

the Department's perspective) with a continuing 2017 arrearage that needed to be paid for petitioner to remain in good standing for 2017, and avoid termination.

3. With the advent of this appeal, the Department recognized that petitioner had been mistakenly informed in March that her payment would satisfy the amount owed (at the time) for 2017, and allowed petitioner through the end of September 2017 – effectively restarting the three-month grace period process - to become current on her account. While extending the grace period, the Department maintained that the use of a portion of the March payment to pay the December 2016 arrearage was proper.

4. However, from petitioner's perspective, what she was informed in March and then the use of her payment to satisfy an arrearage from December of 2016, remained in dispute.[1] In that respect, she sought the right to make payment of her December 2016 arrearage by the end of 2017, a request that the Department denied (and instead, as described above, reset petitioner's grace period and allowed her until the end of September to pay).

[1] The December 2016 arrearage of $409.49 included a premium for dental coverage as well as health insurance.

5. A new hearing officer assumed responsibility for the appeal in August of 2017 and scheduled a telephone status conference for August 11, 2017. Following this status conference, the hearing officer requested a response from the Department regarding petitioner's payment history as well as the nature of her insurance renewal from 2016 into 2017 (which may have affected the application of her December 2016 arrearage to her coverage in 2017).

6. Another telephone status conference was scheduled for August 17, 2017. On that day, petitioner requested a postponement of the status conference, which was denied by the hearing officer, although petitioner's request for additional time to respond to the Department's summary of her payment history was granted.

7. Following the August 17, 2017 status conference, the Department was requested to respond to questions regarding the nature of petitioner's renewal of insurance as well as the inclusion of the premium for dental coverage in her 2016 arrearage amount. The Department filed a response on September 6, 2017, in advance of a telephone status conference scheduled for September 11, 2017.

8. While maintaining and reserving her dispute regarding application of her 2016 arrearage to her 2017

coverage, petitioner made full payment of all amounts owed (at the time) by the end of September of 2017, fully curing her arrearage and paying for October coverage, meaning she was no longer in a grace period and no longer at risk of termination of her insurance. At the same time, the Department informally (at the September 11 status conference) raised the question of whether any cognizable issues or disputes remained in the appeal. During the September 11 status conference, the hearing officer indicated that before issuing any recommendation he would take under consideration whether any issues remained in the appeal, and a telephone status conference was scheduled for October 11, 2017 – which, following a request to continue by the petitioner, was rescheduled for October 25, 2017.

9. Following the October 25 status conference, petitioner was given until November 10, 2017 to contact the Board if she wished to proceed with her appeal.

10. In response to contact from petitioner (prior to November 10) with respect to which it was unclear whether she wished to maintain her appeal (or possibly present new appeal issues), the Board attempted to schedule another telephone status conference in November and then December of 2017; each

time petitioner requested a postponement (based on valid reasons such as scheduling conflicts and illness).

11. At all times during this appeal – despite her expressed frustration with the events at issue - petitioner has consistently maintained an interest in preserving her health coverage in 2017, making all premium payments (which by all accounts she did), and satisfying the arrearage from December of 2016 (for coverage that she wished to retain). Petitioner does not dispute the calculation of her premium or subsidies, nor – despite some initial questions - is there ultimately any dispute as to the amounts of her payments received by VHC.

12. On January 12, 2018, the Department made a formal motion to dismiss petitioner's appeal as moot. The Board scheduled another telephone status conference on February 5, 2018, to hear the motion. Petitioner requested a postponement due to traveling out of the country; this was granted, but petitioner was given until March 9, 2018 to respond to the Department's motion and contact the Board to specify what issues, if any, remained in the appeal. To date the Board has received no response from petitioner.

ORDER

Petitioner's appeal is dismissed as moot.

REASONS

Review of the Department's determination is de novo. The Department has the burden of proof at hearing if terminating or reducing existing benefits; otherwise the petitioner bears the burden. *See* Fair Hearing Rule 1000.3.0.4.

At the outset, there is a threshold question of whether petitioner's appeal presents any live and active issue or cognizable grievance that the Board has jurisdiction to address. To the extent that petitioner sought to maintain her insurance in 2017 and make all payments (including that for December 2016) through the end of 2017, nothing in the VHC rules or the Board's enabling statute provide any *further*

remedy to petitioner here. *See* Health Benefits Eligibility and Enrollment ("HBEE"); 3 V.S.A. § 3091.[2]

Petitioner has not responded to the Department's motion to dismiss; however, with or without a response, there are no other identifiable issues or grievances that *the Board can* address. To the extent that petitioner *could* maintain an action for damages against the Department, this would clearly be outside of the Board's jurisdiction. *See, e.g.*, Fair Hearing No. B-03/08-104, *citing Scherer v. DSW*, Unreported, (Dkt. No. 94-206, Mar. 24, 1999) and *In re Buttolph*, 147 Vt. 641 (1987).

As such, petitioner's appeal must be dismissed as moot. *See* 33 V.S.A. § 3091(d); Fair Hearing Rule No. 1000.4D.

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[2] It is noted that the Department viewed the resetting of petitioner's grace period as an appropriate remedy for the apparently mistaken information given to her in March 2017 regarding her payment of amounts owed at that time. While the application of prior year arrearages to current year coverage is the subject of a somewhat complex and arcane interplay of factual circumstances and federal guidelines, petitioner was effectively mandated to pay the full amount owed at the end of September 2017 to both ensure maintenance of her coverage as well as her dispute over making that payment. *See* HBEE Rules § 64.13 ("An individual who appeals the amount of their QHP premium must pay the billed amount until the appeal is decided for coverage to continue. If the individual wins the appeal, any overpayment will be refunded."). Any Board decision at that point would have been made in October, after the end of her extended grace period.