STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. S-07/17-350
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Appeal of)
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INTRODUCTION

Petitioner appeals a decision by the Department of Vermont Health Access (the Department) denying her request to provide a letter that assumes responsibility for her lack of health care coverage in 2017. A preliminary issue is whether the Human Services Board has jurisdiction to consider the relief sought by petitioner.

The following facts are adduced from testimony during a telephone hearing held on February 14, 2018 and from copies of exhibits received on that date and documents submitted by the Department post-hearing.

FINDINGS OF FACT

1. Petitioner contacted the Department in December 2016 during the open enrollment period in order to enroll in a health plan with MVP for herself and her husband.

2. Because of problems with the data processing system, a bill could not be generated for petitioner’s account and

therefore she did not receive a bill for her health care premium. This problem occurred in December 2016 and continued through June 2017. Petitioner stated that she called the Department every month to ensure that her account remained open and that she had health care coverage. She indicates that she was told that her account would remain open and that bills would be generated. She indicated in emails to the Department that she was setting aside funds to make the premium payments

3. At some point, an exact date was not provided, petitioner's account was closed by the Department. Petitioner stated that she did not receive notice that the account was closed. She stated that she learned that her request for health care coverage was never effectuated by the Department or conveyed to MVP when her health care providers submitted bills to MVP for health care claims for June 2017, including claims related to an emergency surgery.

4. In June 2017, the Department and the petitioner communicated frequently about this problem. The Department acknowledged that the lack of coverage from January through June 2017 was due to an error caused by its data processing system. As a remedy, the Department contacted MVP to inquire whether they would providing retroactive coverage to

petitioner and MVP agreed to do so. The Department then conveyed that offer to the petitioner as follows: if she was able to pay the full $1,916.67 premium for the six-month period of January through June 2017, she would be enrolled in an MVP plan for that period.

5. Petitioner indicated that she was willing to pay the premium so the Department generated a bill for the full premium amount. However, petitioner did not pay the bill as she was extremely concerned that some of her claims might not be paid. She asked for a written assurance from the Department or MVP that all of her claims would all be paid before she made the premium payment. In particular, she wanted an assurance that all claims related to the emergency surgery treatment in June would be paid, including a claim that required prior authorization for the service, and that costs for office visits and prescription costs incurred by her husband from January through June would be covered.

6. The Department did communicate with MVP about petitioner's request. However, MVP indicated that it was unable to review her case until the petitioner was active in their system, in other words, until she paid the premium. Once she was in their system, they indicated that the providers could submit their claims. While they were willing

to review the benefits provided under her plan with her, they would not make any guarantee of payment. They also indicated that if any of her claims were denied, she would have internal appeal rights.

7. Petitioner was not satisfied with this response and did not make the premium payment in 2017.

8. The Department asserts that the remedy it offered was reasonable and that if petitioner had accepted that solution in June 2017, the bills related to her surgery could have been timely submitted to MVP by the providers. Petitioner vehemently disagrees and indicates that at least one of the medical providers related to her surgery indicated that they would be unable to submit all claims for payment because of their inability to obtain prior authorization from the insurer before the treatment was provided. This dispute continued for the remainder of 2017. The Department continued its offer to provide her with retroactive coverage, but Petitioner continued to express the same concerns about the risk of making premium payments and then not having all claims paid.

9. As petitioner did not have health care coverage in 2017, she has been notified by the Internal Revenue Service (IRS) that she owes a tax penalty for non-coverage. Petitioner’s request on appeal is that the Department write a

letter indicating that it was the Department’s error that caused her not to have health insurance in 2017. The Department indicates that they offered a reasonable remedy that would have provided Petitioner with health care coverage.

ORDER

Petitioner’s appeal is dismissed as beyond the Board’s jurisdiction.

REASONS

The Board may not reach the merits of petitioner’s case if it does not have jurisdiction over the subject-matter of the claims. Fair Hearing No. 16,043. In this case, petitioner is asking that the Board require the Department to issue a letter taking responsibility for her lack of health care coverage in 2017.

The scope of the Board's authority to grant relief is set forth in 3 V.S.A. § 3091. In summary, the Board is granted authority to affirm, modify or reverse decisions made by the departments of the Agency of Human Services and the specific power to grant retrospective and prospective benefits. If the Board determines that a department’s position is legally justified, the decision must be upheld even if the Board may

disagree with the results. 3 V.S.A. § 3091(d). Nothing in the rules or law provides for the relief sought by the petitioner.

There is no question that petitioner has experienced significant frustration stemming from the Department's original error. However, the petitioner's request that the Department be ordered to provide a letter taking responsibility for her lack of insurance is not a remedy within the Board's authority and as such her case must be dismissed. 3 V.S.A. §3091.

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