STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-09/17-456
	)	
Appeal of	)	
	)	

INTRODUCTION

Petitioner appeals the denial of retroactive reinstatement of his health insurance coverage, through Vermont's healthcare exchange, by the Department of Vermont Health Access ("Department"). The following facts are adduced from a telephone hearing held November 28, 2017, and documents submitted by the Department.

FINDINGS OF FACT

1. At base, this appeal concerns events related to petitioner's enrollment (as well as enrollment of his family members) in health insurance in 2015, through Vermont's healthcare exchange. During that year, petitioner requested that his son be removed from his insurance plan, as his son was going to enroll separately. As a result of that change, petitioner began paying a different (lower) premium amount for his and his spouse's coverage beginning in September of 2015. Throughout this time petitioner was obligate to pay

the full, unsubsidized premium amount, as he was not income eligible for an advance tax credit towards his premium.

2. Due to issues with billing on his account, whether as a result of the change in his plan and premium or some other reason, petitioner experienced numerous problems making premium payments during this period, which appear to have been out of his control. For its part, the Department acknowledges that there were systemic problems with the Vermont Health Connect ("VHC") billing system at the end of 2015 and early 2016. In petitioner's case, he was left at the end of 2015 with a lack of clarity as to the status of his account and payment activity (at a later point it was determined that he had made full payment through October 31, 2015, and a partial payment for November of 2015).

3. In early 2016, petitioner contacted VHC to ascertain the status of his account. In February of 2016, he was told that his payment activity still needed to be updated, and it made sense to wait until that was clarified to make a payment.

4. On March 3, 2016, petitioner spoke to a customer service representative, who – according to the credible summary note of that conversation – informed him of his outstanding balance for the remainder of 2015 and for 2016

coverage up to that point, and gave him a reference number to note on the check he was (presumably) planning to send. While this note appears to show that petitioner was given the information he needed at the time to address his account balance, petitioner disputes that he was clearly or accurately informed of what he needed to do to ensure the remainder of his 2015 coverage at that point. For reasons stated below, this dispute is not material to the outcome here.

5. Petitioner made no payments in 2016 and his next contact with VHC came in October of 2016 – apparently following the Department's mailing of an invoice to him reflecting an outstanding balance.

6. Petitioner's contact with the Department was converted into a request for an appeal, which was processed internally with VHC's fair hearing unit. On October 12, 2017, petitioner's insurer mailed him a letter confirming that his 2015 health insurance had been terminated as of October 31, 2015 (the letter also included a notice of his appeal rights).

7. On November 10, 2016, a VHC fair hearing specialist spoke with petitioner on the phone, and explained that the only action the Department could (or would) take is to

arrange for a refund of the partial premium he paid for November of 2015. At that time, the case notes by the fair hearing specialist, which are deemed credible, indicate that petitioner withdrew his appeal. In connection with this phone conversation, the fair hearing specialist wrote an email to petitioner on the same date, stating (in pertinent part) "[p]lease see attached spreadsheet. Refund was resubmitted today. Please call if you need anything else. I hope this will resolve any outstanding issues."

8. Based on the above, the record establishes that petitioner was clearly informed that his insurance had terminated as of October 31, 2015 (along with appeal rights related to such) and had an internal appeal opened and then resolved by his withdrawal of the appeal.[1]

9. Petitioner accepted the refund and did not respond or contact VHC again until February 1, 2017, after he had received an outstanding bill for medical services dating back to November of 2015. This appeal followed.

10. Petitioner seeks reinstatement of his coverage for November (at a minimum) of 2015. He indicates that he has

[1] No appeal was docketed by the Board at that time, nor is there any basis in the record to find that an appeal should have been sent to the Board at that time, due to petitioner's withdrawal and the apparent resolution of his issues.

been frustrated and confused about the status of his 2015 insurance coverage, asserts he has made numerous and unsuccessful attempts to clarify such, and alleges generally that this is the fault of the Department and/or Vermont Health Connect.

ORDER

Petitioner's appeal is dismissed as untimely.

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 – when the appeal concerns an initial denial of eligibility - the petitioner bears the burden. *See* Fair Hearing Rule 1000.3.0.4.

This appeal presents the threshold question of the Board's jurisdiction. The applicable rules for appealing a decision related to a Qualified Health Plan through Vermont's healthcare exchange (as here) require the appeal to be submitted within 90 days of notice of the decision. *See* Health Benefits Eligibility and Enrollment ("HBEE") Rules § 80.04(c).

In this instance, even if overlooking the fact that petitioner withdrew his internal appeal as of November 10, 2016 – he did not contact VHC until February 1, 2017, regarding his current appeal. This is well past 90 days of the *latest* date that he was informed his insurance was terminated, by letter dated October 12, 2016. There is nothing in the record establishing that petitioner was misled or confused by any action or communication from the Department; if anything, as of October of 2016, he was clearly informed of the status of his insurance and ultimately appeared to be satisfied with the resolution of his internal appeal – accepting the refund for the time period of November, 2015.[2]

As such, the Board lacks jurisdiction over petitioner's appeal, which should be dismissed as untimely. *See* 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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[2] While it does not affect whether the Board has jurisdiction over his appeal, it is noted that petitioner did not make any payments, or inquire any further, in the several months following being told in March of 2016 that he had an outstanding balance for 2015 coverage.