STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. R-10/17-529
	)	
Appeal of	)	
	)	

INTRODUCTION

Petitioner appeals the termination of her insurance, for nonpayment of premiums, through Vermont's healthcare exchange, and the corresponding denial by the Department of Vermont Health Access ("Department") to reinstate her coverage. The following facts are adduced from a telephone hearing held November 21, 2017, and documents submitted by the Department on January 2, 2018.[1]

FINDINGS OF FACT

1. Petitioner was enrolled in health insurance through Vermont Health Connect ("VHC") for calendar year 2017. She received individual coverage which, including federal and state subsidies, resulted in a premium obligation of $26.41 per month.

[1] Although there was some delay in the Department providing this information, this was not prejudicial to petitioner, as for all practical purposes the earliest the Board could have considered this appeal was at its January 2018 meeting, which would have presented the same issue here of retroactive reinstatement of petitioner's 2017 coverage.

2. Petitioner was current on her premiums as of the end of May of 2017, meaning she had paid all premiums for the year up to and including for June coverage. She had contacted VHC on May 31, 2017, to make her payment for June as well as for unpaid premiums in prior months, making a total payment of $79.23. During that phone conversation (based on case notes produced by the Department), petitioner indicated an interest in setting up automatic payments. Petitioner was transferred to the payment line to make the payment of $79.23 and to (presumably) set up automatic payments. However, the entry from petitioner's call to the payment line - which calls are not recorded - indicate that petitioner did not or declined to set up automatic payments. If petitioner had set up automatic payments, credible evidence from the Department establishes that would have been included in the note, as it would have entailed provision of her bank account information and the amount of the authorized payment. Petitioner does not recollect with specificity what she discussed with the payment line or dispute the summary of the call entered into the Department's records.

3. On June 6, 2017, VHC mailed petitioner an invoice indicating she had a current amount due of $26.41. This premium notice (and all notices described herein) indicated

that the premium was due by the 26th of the month, must be paid in full, and would be considered late unless made by the end of the month. Payments are considered made (if by check) as of the date postmarked.

4. Petitioner made no payments in June. As a result, petitioner's next (dated July 7, 2017) invoice from VHC showed a current amount due of $26.41 and a "past amount" due of $26.41, for a total amount due of $52.82. In addition, petitioner's insurer mailed her a letter (also dated July 7, 2017) notifying her that her premium payment was late, she was in a grace period ending September 30, 2017, and needed to pay the entire amount due on her invoice to become current on her premiums. The notice explained the grace period process and that failure to become current on premiums due, prior to the end of the grace period, would result in termination of coverage (retroactive to July 31, 2017).

5. Petitioner made no payments in July. VHC mailed her an invoice dated August 6, 2017, indicating she had a current amount due of $26.41 for September coverage and a "past amount" due of $52.82, for a total amount due of $79.23. Her insurer also mailed her a letter dated August 8, 2017, that her premium payment was late, and she remained in a grace period, along with the same information described

above as to operation of the grace period. It is noted that this letter indicated that her grace period would end on October 31, 2017, not September 30 as indicated in the previous month's letter.[2]

6. Petitioner made no payments in August. Subsequently, VHC mailed her an invoice dated September 8, 2017, indicating that she had a current amount due of $26.41 for October coverage and a total amount due of $105.64.

7. Her insurer mailed her a letter dated September 7, 2017 indicating that she remained in a grace period, ending on September 30, 2017, and (as specified in prior grace period letters), she needed to pay the full amount on her VHC invoice or her coverage could end – along with the same information about how the grace period system operates.

8. Petitioner made no payments in September. During the three months (July, August and September) that she was advised by letter of being in a grace period, and receiving invoices showing a past due amount, she made no contact with VHC. On October 4, 2017, her insurer mailed her a letter notifying her that her insurance had been terminated,

[2] While the October 31 date was erroneous, as described below it was followed by a notice with the correct date of September 30, and in any event, there is no evidence that the isolated reference to October 31 in this notice misled or confused petitioner.

effective July 31, 2017. Following this letter, petitioner contacted VHC to pay her past due amount and reinstate her insurance. Because her grace period had ended, this request was denied.

9. Petitioner is not certain if she received all of the notices and invoices specified above (although there is no evidence contrary to the record establishing that they were mailed). Although termination of her insurance applies only to calendar year 2017, petitioner has chronic health conditions and medical bills for which she seeks retroactive coverage, and there is no question that her loss of insurance has posed significant financial and medical issues for her.

ORDER

The Department's decision is affirmed.

REASONS

Recipients of health insurance through VHC are required to pay premiums in the month prior to the month of coverage. *See* Health Benefits Eligibility and Enrollment ("HBEE") Rules § 64.00(g). The rules allow the insurer to terminate coverage for nonpayment of premium(s) after the expiration of a three month "grace period" for individuals receiving a

federal subsidy through an Advance Premium Tax Credit (APTC). *See* HBEE Rules § 76.00(b)(2)(i)(A).

The three-month grace period is established in rule for individuals enrolled in a health plan through VHC and receiving an APTC subsidy. *See* HBEE Rules § 64.06(a)(1)(i).[3] The grace period remains in effect so long as the enrollee is not fully current on their healthcare premium, for a maximum of three consecutive months, after which coverage is terminated. *See* HBEE Rules § 76.00(b)(2)(i)(A). Under the regulations, the insurer has the obligation of providing notice of the grace period to the enrollee. *See* HBEE Rules § 64.06(b)(1)(i)(A) (specifying content of notice). If the nonpayment is cured in full after commencement of the grace period and prior to expiration of three consecutive months, the grace period ceases and termination of coverage is averted.[4] If coverage is ultimately terminated for nonpayment, it is effective as of the end of the first month of the grace period. *See* HBEE Rules § 76.00(d)(4).

[3] Individuals not receiving a subsidy have a grace period of one (1) month. *See* HBEE Rules § 64.06(a)(1)(ii).

[4] The grace period is not cumulative if it is interrupted by fully curing the nonpayment. If the nonpayment is cured while the period is in effect, the grace period ends, as it must run for three (3) consecutive months to result in termination. *See* HBEE Rules § 64.06(b).

The record here establishes that the premium bills and the grace period notices were mailed, as required by the rules. The grace period notices have consistently been upheld by the Board as sufficient to advise beneficiaries of the consequences of nonpayment, as well as the opportunity to contact VHC with questions. *See* e.g. Fair Hearing No. B-06/17-267. Under these circumstances, notice was reasonably given, and petitioner failed to make timely payments of her premium.

As such, the termination of petitioner's insurance and the Department's denial of reinstatement is consistent with the applicable rules and must be affirmed. *See* 3 V.S.A. § 3091(d), Fair Hearing Rule No. 1000.4D.

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