STATE OF VERMONT

HUMAN SERVICES BOARD

In re	)	Fair Hearing No. B-06/18-445
	)	
Appeal of	)	
	)	

INTRODUCTION

Petitioner appeals a one-month decrease in her premium subsidy by decision of the Department of Vermont Health Access (Department). The following facts are based upon a telephone hearing held September 27, 2018[1] (earlier hearings were scheduled on August 9th and September 14th, but petitioner was not available on those dates) and records submitted by the Department at hearing along with post-hearing filings by the Department dated October 10 and December 4, 2018.

FINDINGS OF FACT

1. Petitioner and her family (a household of three) were enrolled in insurance through Vermont's health insurance

[1] After the hearing in this matter, the hearing officer requested that the Department respond to a question regarding the operation of grace periods in light of practices and procedures of federally-related health benefits exchanges (as opposed to Vermont's state-based exchange). Due to the complex nature of this issue, the Department was granted additional time to respond. The delay occasioned by this inquiry and response was not prejudicial to petitioner, given that it might have affected the Department's position as to operation of the grace period in Vermont (this issue is more fully explained below, in footnote 2).

exchange (Vermont Health Connect or VHC) for calendar year 2018. They were determined eligible for federal and state subsidies amounting to $793.97 per month, which resulted in a premium obligation of $253.95 per month.

2. In or around January of 2018, VHC was notified by the federal government of a potential discrepancy in petitioner's income. The Department mailed the household three letters dated January 15th, February 14th, and March 19, 2018 requesting that petitioner verify her income with paystubs or other information. The letters requested a response by April 16, 2018 and indicated that petitioner's benefits through VHC could end if income verification was not provided. The final letter stated, "**FINAL REMINDER: Information Needed by April 16, 2018.**"

3. The Department's case notes reflect that petitioner called the Department on March 29th inquiring about the income verification request; the Department states that petitioner was again requested to send in documentation, such as paystubs, to verify current income. The case notes also reflect a May 11th note stating "sent income information and faxed income not in attachments checked other contact records under same notes none had attachments."

4. On May 4, 2018, VHC mailed petitioner a notice stating that as it had not received requested income verification information, the family's eligibility for financial assistance had been recalculated and that effective June 1st the APTC would decrease from $793.97 to $464.47 (and Vermont Premium Assistance was slightly increased). The resulting cost of their premium increased from $253.95 to $564.80. The May notice included information about appealing the decision as well as the opportunity to request "continuing benefits" by contacting VHC on or before the effective date of any change.[2]

5. In response to that notice, petitioner contacted VHC by phone on May 11th. Petitioner then mailed income information and called the Department on June 4th to verify receipt; the Department confirmed receipt of the information on May 29th (prior to the June 1st effective date referenced in the notice) but indicated that the information had not yet

[2] The Department's May 4, 2018 notice to petitioner includes the following notice language: "Can I keep my coverage or keep my premium the same while I appeal? Yes. When you appeal, tell us you want "continuing benefits." This means you want your health care coverage to stay the same during the appeal. . . Are you on a qualified health plan (QHP)? You may have to pay back federal premium assistance (APTC) when you file your taxes if you get too much in advance." Of note, the information concerning continuing benefits specifically mentions APTC and the fact that any overpayment of the tax credit would need to be repaid when taxes are filed. In a later provision, the notice also stated that (apparently in cases when continuing benefits are not requested) petitioner would have to pay the new higher premium amount in order to continue coverage during her appeal.

been processed. The new income information from petitioner was $12,000 in annual earnings, which was a slightly higher amount than the previously reported information of $9,740.29.

6. The Department then recalculated petitioner's income information and determined that effective July 1st, petitioner was eligible for slightly more APTC than had been awarded prior to the verification process; petitioner's new APTC amount was $796.87 resulting in a premium of $248.32 per month.

7. Petitioner appealed the change in subsidy amount on June 12th, stating that she was unable to pay the higher premium amount, also noting her position that she had submitted income information on a timely basis.

8. Meanwhile, when petitioner did not timely pay the increased premium amount that she has been billed for June coverage, she was notified by the carrier that she was in a 90-day grace period[3]. In July, the second month of her grace

[3] As noted above, the hearing officer requested that the Department respond to the practice of the federal exchange (and state exchanges operating on the federal platform) with respect to operation and curing of the grace period. See "Federally-facilitated Exchange (FFE) and Federally-facilitated Small Business Health Options Program (FF-SHOP) Enrollment Manual" (6/26/2018) (www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Enrollment-Manual-062618.pdf). This federal guidance – albeit not binding on state exchanges such as Vermont's – allows for a grace period to be cured by making payment of an enrollee's "past due" amount and does not require payment of an upcoming month to cure the grace period. While acknowledging that the federal practice (based on the same federal regulations guiding Vermont's exchange)

period, her coverage was placed on 'hold' status and she was unable to fill needed prescriptions.

9. Petitioner testified at hearing that this 'untimeliness' occurred because when the Department decreased her subsidy, she discontinued the automatic payment option she had previously used to process her payments until she could straighten out the premium amount with the Department; petitioner did not want to pay the higher June premium as she believed it was incorrect. However, when her coverage was placed on 'hold' status, petitioner decided to pay the amounts on the invoices she had received (including the higher premium amount for June) in order to use her insurance. As a result, on the date of hearing, petitioner's

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differs from Vermont's practice, the Department offers several bases for the manner in which the Vermont exchange currently operates: 1) that this practice was developed with the input of all stakeholders, including Vermont's Healthcare Advocate; 2) it is a practice that under the federal regulations is within Vermont's discretion, and 3) that including the amount due for an upcoming month in the current month is a reasonable interpretation of the requirement to pay "outstanding" premiums due. The federal regulations allow for some discretion in the establishment of a payment and premium system, see 42 C.F.R. §§ 155.240 and 155.400, and the Department points to a VHC policy which specifically adopts Vermont's practice towards curing the grace period. See DVHA "Enrollment and Billing Timelines" Manual (November 2015). Moreover, federal rules or interpretations of those rules which might be directly applicable to state exchanges do not – at this point – clearly contradict Vermont's practice. See, e.g., 77 Fed.Reg. 18310, at 18427 (March 27, 2012) and 82 Fed.Reg. 18346, at 18350 (April 18, 2017). As such, the Department's practice is accepted as meeting at least a "rational basis" test for implementation of the regulations and the existence of a different federal practice does not merit reversing Vermont's practice. However, this issue may be revisited by the Board if countervailing and clear federal (or other) interpretations, rules or requirements emerge in the future.

account was current. Petitioner stated that she still wanted to appeal the original decrease in subsidies for the month of June.

10. The Department's position is that retroactively adjusting petitioner's June subsidy amount is not the appropriate remedy. Rather, the Department states that once it received the requested verification information in June, it adjusted petitioner's premium subsidies prospectively as it asserts is proper under the rules.

ORDER

The Department's decision is affirmed.

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.

The Department is obligated under certain circumstances to verify reported income. *See* Health Benefits Eligibility and Enrollment ("HBEE") Rules § 56.00 [Verification]. Upon discovering any discrepancy between the information reported by a household and that reported by various government data

sources, the Department is required to request income verification from the household pursuant to § 57.00(c) which establishes the 90-day opportunity period for provision of information. If the household either is unable to provide verification or does not respond to the request, the Department is authorized to reduce or remove the subsidies. Rule § 56.08(c).

Here, petitioner asserts that she did submit information to the Department on a timely basis, however, she was unable to provide any specific dates when that might have occurred and the Department's case notes reflect phone conversations with petitioner during the verification process which support the Department's position that no verification information was received until May 29th.

On May 4, 2018, lacking the information necessary to determine continued eligibility for subsidies the Department recalculated petitioner's premium using the federal data that it had received pursuant to § 73.06(a)(3) of the rules. The Department notified petitioner that the new premium with a lower subsidy would become effective on the first day of the following month, which was June 1, 2018.

Then, on May 29th, the Department did receive new income verification information from petitioner. In response to

petitioner's submission the Department recalculated petitioner's eligibility and indicated that the new premium amount, with higher subsidies, would become effective on first day of the second month following the provision of the information pursuant to Rules§§ 73.05(a), 73.06(c) and 73.06(b).

When the Department did recalculate her slightly increased income, as reflected in the "2018 Advance Payments of Premium Tax Credit (APTC) Worksheet" dated June 14, 2018, it correctly took into account the lower subsidy that she received in June and factored that in to the subsidies she would receive for the remaining six (6) months of 2018, resulting in a slightly lower premium of $248.23 (compared to the pre-verification process premium of $253.95). This means that petitioner has received all the APTC subsidy she was entitled to during 2018, and that she has recovered any overpayment of premium she made in June 2018.

It should be noted that the Department's failure to offer petitioner, who was appealing the removal of her subsidies, the option of paying the pre-verification premium during the pendency of the appeal is in conflict with the Department's notice which cites the "continuing benefits" rule.

The VHC rules and federal rules clearly allow for continuing benefits pending an appeal[4]:

> **Continuation of eligibility for enrollment in a QHP, APTC, and CSR pending appeal of redetermination.**
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> After receipt of a valid fair hearing request or notice that concerns an appeal of a redetermination, if the individual (appellant) accepts eligibility pending an appeal, AHS will continue to consider the individual (appellant) eligible, while the fair hearing is pending, for QHP, APTC, the Vermont Premium Reduction and federal or state CSR, as applicable, in accordance with the level of eligibility immediately before the redetermination being appealed.

HBEE Rules § 82.00(m); *see also* 45 C.F.R. § 155.325.

For these reasons, when petitioner appealed and notified the Department that she could not afford to pay the higher premium for June, petitioner should have been given the option for continuing benefits (along with the warning that she was accepting tax liability should there be an overpayment of subsidies). Indeed, in this case, petitioner stated that she was not able to pay the higher June coverage amount and entered a grace period that ended only when she

[4] Federal guidance strongly suggests that this is a fundamental due process requirement for those enrollees faced with loss of their subsidy due to a federal data-matching issue. See 83 FR 16930-01, at p. 16983 (April 17, 2018). The language of the rule and federal guidance also appear to assume that an appellant will be asked if they wish to accept the level of eligibility preceding the redetermination under appeal. See 78 FR 54070-01 (August 30, 2013).

had to pay the higher June premium in full in order to avoid termination of coverage.

However, as petitioner has now recovered the premium subsidy due to her, she is no longer aggrieved by the Department's decision. If she had received her prior (pre-June) subsidy in June 2018, she would have received less APTC over the remainder of the year.

For the above reasons, the Department's decision must be affirmed; any remaining issue as to payment of APTC in June 2018 has been rendered moot. See 3 V.S.A. § 3091(d); Fair Hearing Rule No. 1000.4D.

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