STATE OF VERMONT

HUMAN SERVICES BOARD

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| In re | ) | Fair Hearing No. B-01/15-11 |
| | ) | |
| Appeal of | ) | |

## INTRODUCTION

The petitioner appeals a decision of the Department for Children and Families, Economic Services Division denying her request for reimbursement for premium payments she made to maintain private insurance due to the Department's failure to notify her that she was eligible for Medicaid. The preliminary issue is whether the Board has jurisdiction to consider the matter.

The following facts are not in dispute, and are based on the representations of the parties at a hearing held on February 26, 2015.

## FINDINGS OF FACT

1. The petitioner, who was unemployed at the time, applied online for health insurance through Vermont Health Connect (VHC) in the Fall of 2013 during the Department's initial open enrollment period for coverage beginning in January 2014. She had previously been covered through a

COBRA plan based on her previous employment. Her COBRA coverage under that plan had ended in October 2013.

2. Consistent with the well documented problems with the Department's implementation of VHC, the petitioner received no response from the Department regarding her application, and she was unable to get through to VHC by phone.

3. In January 2014, having heard nothing from the Department regarding her VHC application, the petitioner enrolled in her partner's employer sponsored health plan effective February 14, 2014. Her premium to be included in her partner's plan was about $400 a month.

4. In August 2014 VHC notified her that she had been found eligible for Medicaid effective January 1, 2014. Prior to August 2014 she had received no notice, ID card, or other indication from VHC that she was eligible for Medicaid. The August notice informed her that she would be receiving a Medicaid ID card.

5. Despite receiving this notification from VHC in August, the petitioner (understandably) "doubted" its accuracy, and continued to maintain her insurance through her partner's employer plan, and continued to pay the $400 premiums for that coverage.

6. Under VHC rules, the petitioner's eligibility for Medicaid "rolled over" into 2015. In January 2015 she received, *for the first time*, a Medicaid card from VHC. VHC subsequently informed her that she had, in fact, been covered by Medicaid since January 2014.

7. The petitioner paid about $4,800 in premiums in 2014 to maintain her health coverage through her partner's employer plan, which it now appears was entirely unnecessary. The Department has refused the petitioner's request that it reimburse her for this amount.

8. It appears, however, that the insurer who provided the petitioner's health coverage in 2014, and the providers who received payment from that insurer to provide medical services to the petitioner last year, may be willing to negotiate "refunds" if the providers can receive retroactive Medicaid coverage for those services. The Department represented at the hearing that it is willing to assist the petitioner in these negotiations, and to provide retroactive Medicaid coverage if the carrier and the providers are willing to accept it. At this time, however, it is impossible to determine whether this scenario can actually be

accomplished, or whether the possibility of it exists only in the abstract.[1]

ORDER

The petitioner's appeal is dismissed at this time as being beyond the Board's jurisdiction. However, the petitioner shall retain the right to file a subsequent appeal to the Board if she is dissatisfied with the Department's efforts and assistance in negotiating a resolution with her providers and the 2014 insurance carrier.

REASONS

The Board has recently held that there is no provision in the VHC regulations authorizing or contemplating "reimbursements" to individuals for payments made to providers or insurers for medical services or coverage that have already been provided to that individual. (See e.g. Fair Hearing Nos. B-01/15-08 and B-10/14-1004.) In this case, as in the others, there is no claim or indication that

[1] It appears that each provider who treated the petitioner in 2014 would have to agree to accept retroactive Medicaid payments for those services from the Department, and to reimburse the insurance carrier for the coverage the carrier provided to them for those services. The insurance carrier would then have to agree to refund to the petitioner the premiums the petitioner paid for coverage in 2014 once it has been reimbursed by its providers for the claims it paid to them to provide those medical services to the petitioner.

*the insurer* was in any way at fault. It provided health care coverage to the petitioner in 2014, and there does not appear to be any legal basis for the Department or the Board to require the insurer to refund the premium payments the petitioner made for this coverage.

Thus, at least at this point, the petitioner's grievance amounts to a claim for monetary damages *against the Department*. Based on at least two Vermont Supreme Court rulings (one affirming a ruling by the Human Services Board) holding that "an administrative agency may not adjudicate private damages claims", the Board has consistently denied such claims. 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).

However, as noted in the previous cases, the Board's lack of jurisdiction does nothing to decide whether the petitioner may have a justiciable complaint against the Department *in another forum*, and the petitioner may be well advised to seek legal advice and to take other legal action if subsequent negotiations with the carrier and its providers

fail to resolve or mitigate her financial loss.[2] In the meantime, the Board will assume the Department's good faith in its offer of assistance to the petitioner to resolve the matter through negotiation with the carrier and those providers. The petitioner is free, however, to file a subsequent appeal *to the Board* if she is dissatisfied with the Department's sincerity or efforts in that regard.

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[2] The Board has noted that considering the scope and severity of the problems that occurred in implementing VHC, and the likelihood that some individuals, like the petitioner, may well be able to demonstrate that they incurred significant financial losses directly attributable to the Department's mistakes, misinformation and delays, the Department may well be advised to consider establishing a mechanism and funding to administratively process and adjudicate individual monetary claims by adversely affected VHC applicants and recipients.