STATE OF VERMONT

HUMAN SERVICES BOARD

In re) Fair Hearing No. B-02/15-126
)
Appeal of)

INTRODUCTION

The petitioner appeals a decision of the Department for Children and Families, Economic Services Division denying his request to waive premium payments he will be required to make to maintain his health coverage under the Vermont Health Connect (VHC) program. The preliminary issue is whether the Board has jurisdiction to consider the matter.

Except as specifically noted, the following facts are not in dispute, and are based on the representations of the parties at a hearing held on March 6, 2015.

FINDINGS OF FACT

1. The petitioner has been enrolled in VHC since early in 2014. On November 4, 2014 the petitioner called VHC to request switching his insurance coverage from one of the insurers participating in VHC (MVP) to the other (BC/BS), effective January 1, 2015. When he did not receive written confirmation of the switch he called VHC again on December 16, 2014.

2. The petitioner does not dispute that he received a written "renewal notice" from VHC at the end of 2014 that advised all current participants in the program that they would be eligible automatically for rollover coverage effective January 1, 2015 despite anticipated delays in the Department being able to provide written confirmation of such coverage. The petitioner also does not dispute that during both of his phone conversations with VHC he was informed that there would be no gap in his insurance coverage, even with the change from one insurance carrier to the other.

3. The Department did not provide the petitioner with written confirmation of his coverage through BC/BS until on or about January 30, 2015, and he did not receive any premium bills or notices before then. The notice he received on January 30 confirmed his insurance coverage effective January 1, 2015. Either then, or shortly thereafter, the petitioner received a bill for premium payments for January and February 2015.

4. The petitioner did not incur any medical expenses in either January or February 2015. He alleges that he held off going to the doctor during those months as a precaution because he was not sure if he was covered. He does not allege that there is any medical evidence that his health

suffered as a consequence of him not scheduling medical appointments in that time.

5. The petitioner maintains that due to the Department’s delay in providing him with written confirmation of his 2015 coverage he should not have to retroactively pay any premium for January and February 2015 in order to maintain coverage effective March 1, 2015. He does not dispute, however, that he would have been covered by his insurer had he filed any claims during January and February.

6. The petitioner also does not allege that anyone speaking for the Department or either insurer advised him or led him to believe that he would not owe a premium for health coverage in January or February 2015. Nor does he maintain that he made any request prior to January 30, 2015 that he be retroactively disenrolled or “suspended” from coverage for January 2015; and it does not appear that he communicated a desire to forego coverage for February 2015 at any time prior to the date of his hearing on March 6, 2015.

ORDER

The petitioner’s appeal is dismissed as beyond the Board’s jurisdiction.

REASONS

The Board has jurisdiction to decide, but has held that there is no provision in the VHC regulations authorizing or contemplating credits or reimbursements to individuals for payments made or owing to insurers for medical coverage that has 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 that *the insurers* were in any way at fault. One or both of them did, in fact, provide health coverage for the petitioner respectively for the months of January and February 2015, even though the petitioner did not make any claims. Thus, there does not appear to be any legal basis to now require the insurer to “credit” the petitioner for the premium payments that are retroactively due for that period.

At this point, in light of the above, it must be concluded that the petitioner's grievance amounts to a claim of monetary liability or 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).

The Board's lack of jurisdiction at this time does not decide whether the petitioner may have a justiciable complaint against the Department *in another forum*. See 12 V.S.A. 5603. This is not to suggest or speculate that the petitioner would, or should, prevail in such a claim, but to note that the petitioner is nonetheless free to seek legal advice and to take other legal action if he still feels aggrieved.

However, for the above reasons, the petitioner's appeal to the Board at this time must be dismissed.

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