STATE OF RHODE ISLAND
EXECUTIVE OFFICE OF HEALTH AND HUMAN SERVICES
APPEALS OFFICE

[redacted]

V. DOCKET No. 24-3626

HealthSource Rhode Island

DECISION

INTRODUCTION

A virtual hearing on the above-entitled matter came before an Appeals Officer on July 9, 2024, at 1:00 PM. The Appellant, [redacted], initiated this matter to appeal the Qualified Health Plan (QHP) disenrollment for non-payment made by HealthSource Rhode Island (HSRI). For the reasons discussed in more details below, the Appellant's appeal is dismissed on grounds the Appellant's requested relief cannot be granted.

JURISDICTION

The Executive Office of Health and Human Services (EOHHS) is authorized and designated by R.I.G.L. § 42-7.2-6.1, EOHHS regulation 210-RICR-10-05-2, and HSRI regulation 220-RICR-90-00-1.14 to be the entity responsible for appeals and hearings related to HSRI and the Health Exchange. The administrative hearing was held in accordance with the Administrative Procedures Act, R.I.G.L. § 42-35.1 et. seq., and EOHHS regulation 210-RICR-10-05-2.

ISSUE

The issues before this Appeals Office are whether the cancellation of the Appellant's coverage due to non-payment was done in compliance with Federal and State Policy and if the relief the Appellant is seeking can be granted.

STANDARD OF PROOF

It is well settled that in formal or informal adjudications modeled on the Federal Administrative Procedures Act, unless otherwise specified, a preponderance of the evidence is generally required to prevail. This means that for each element to be proven, the factfinder must believe that the facts asserted by the proponent are more probably true than false. 2 Richard J. Pierce, Administrative Law Treaties § 10.7 (2002) & see *Lyons v. Rhode Island Pub. Employees Council 94*, 559 A.2d 130, 134 (R.I. 1989) (preponderance standard is the "normal" standard in civil cases). When there is no direct evidence on a particular issue, a fair preponderance of the evidence may be supported by circumstantial evidence. *Narragansett Electric Co. vs. Carbone*, 898 A.2d 87 (R.I. 2006).

PARTIES AND EXHIBITS

Present were the Appellant and HSRI General Counsel Ben Gagliardi, Esq. The following exhibits were presented as evidence:

- HSRI Exhibits:
    - Disenrollment Notice issued to the Appellant on December 31, 2023.
    - Note from HSRI's system on the Appellant's case titled *12/18 ACH Payment*.
    - The Appellant's payment history with HSRI.
    - HSRI invoice issued on December 6, 2023, to the Appellant for January 2024 coverage.
- Appellant Exhibits:
    - Letter/Statement from the Appellant titled *Appeals Case Against Health Source RI.docx*

RELEVANT LAW/REGULATIONS

Payments

Someone who is obtaining health insurance through HSRI is required to make the first month's premium prior to the start of the month of coverage. 220-RICR-90-00-1.6(C)(1) & (D)(2) & HealthSource Policy Manual @ 122. This must be completed by the 23rd of the previous month to effectuate coverage for the following month. Once someone is on coverage they can be terminated for several reasons, including the failure to pay premiums on time. When there has been one (1) payment made and the person is receiving tax credits to help pay for the coverage, they are entitled to a three (3) month grace period. If the person fails to pay **ALL** outstanding premiums during the grace period, then HSRI can terminate the coverage. Such termination is effective for the last day of the first month of the grace period. Overdue accounts are sent late notices which include the payment amount overdue, the applicable grace period, and the expected coverage termination date. 45 C.F.R. § 155.430 (b)(2) & (d)(4), 220-RICR-90-00-1.10 (B – D), & Healthsource Policy Manual @ 119-121.

ACH Payments

Someone purchasing health insurance through HSRI can set up automatic withdrawals from a bank account via Automated Clearing House (ACH) Electronic Funds Transfer (ETF) transaction. This allows the monthly premium to be automatically paid without additional intervention from the applicant. HSRI retains the discretion to carry forward recurring payments from one policy year to another, but applicants may be required to set new payment schedule every year. If someone is set up on reoccurring automatic payments, there will be a notation on the invoice being sent of the automatic payment. If an applicant believes they have automatic payments set up but does not see the notation on the invoice, they need to contact HSRI or review their online account to confirm payment information is correct. Healthsource Policy Manual @123.

Relief

45 C.F.R. § 155.545(c) sets for the implementation of an appeal decision. That rule specifies that HSRI must promptly implement the appeal decision effective either prospectively on the first day of the month following the decision or retroactively to the coverage effective date had they been correctly enrolled under the issue on appeal. This is at the Appellant's option.

Individual Mandate Waivers.

HSRI is authorized to issue waivers to the minimum essential coverage mandates, both federal and state. Someone wishing to obtain an exception to the mandates must first complete an application with HSRI for the exemption. If the application is denied by HSRI the applicant can then request an appeal with EOHHS. 45 C.F.R. §§ 155.610 & 155.635, 220-RICR-90-00-1.11, & Healthsource Policy Manual @ 92 - 95.

OBJECTIONS AND MOTIONS

HSRI raised the objection that the relief being sought by the Appellant is outside what can be granted by this tribunal. As the issue directly impacts the decision of this case, the issue is discussed in detail in the discussion of this decision.

FINDINGS OF FACT

1. The Appellant has been purchasing health insurance through HSRI for several years. The Appellant was paying $107.25 a month for his 2023 plan.
2. In December 2023, the Appellant called to review his plan for 2024. At that time, he selected a new medical and dental plan that totaled $428.87 a month. No binder payment was made at that time as, according to HSRI, the Appellant needed to confer with his PCP first.
3. In January 2024, the Appellant realized he was not covered when he tried to fill a prescription. He called HSRI and got enrolled in a plan including making the first month's payment.

4. The Appellant assumed his plan was on automatic payment. The plan the Appellant selected in December was approximately three (3) times the cost of his previous plans which caused HSRI to cancel the automatic withdrawals.
5. Payments for February onward were not automatically withdrawn and were not manually made.
6. The Appellant was terminated because of the non-payments in accordance with the grace period policy.
7. The Appellant is seeking to have HSRI pay for February and March premiums or to have those months not count towards not having coverage for the individual mandate.
8. HSRI has a note from January that HSRI was supposed to reach out to the Appellant to reestablish the automatic payment. HSRI does not have a record of placing this call. As such HSRI is allowing the Appellant to reenroll into his plan either prospectively or retro back to February based on 45 C.F.R. § 155.545(c).

DISCUSSION

The issue in this case boils down to if the relief the Appellant is seeking can be granted. For the reasons discussed below the relief cannot be granted.

The first option for relief requested by the Appellant is to have HSRI cover the costs for February and March health insurance. In this case, policy does not permit a decision for HSRI to cover those costs. Federal policy lays out rules regarding the implementation of an appeal decision. Specifically, it permits reinstatement of coverage retro to the lost under appeal or prospectively from the next month onwards. It does not specify that HSRI can cover someone's premiums. This trihunal is limited to what is set forth in policy. Absent policy providing that as a remedy, it's beyond this tribunal's ability to offer such a remedy. Furthermore, such a remedy would generally come out of equity law. Courts have well established that equity remedies do not exist on the administrative hearing level or when said decisions are reviewed by the courts.

The second option for relief requested by the Appellant is that February and March do not count as not having coverage under the individual mandate. In this case the relief cannot be granted by this tribunal as the issue is not ripe for review. HSRI is authorized to issue waivers to the individual mandate. To request a waiver the Appellant must first apply for a waiver to HSRI. Once submitted, HSRI will decide on the application. Once HSRI makes a ruling on that application, would this tribunal be able to intervene. HSRI testified that they have not received a waiver application from the Appellant yet and no evidence was presented to the contrary. Until said application is submitted and decided by HSRI, there is no agency action required for this tribunal to have jurisdiction on the issue of an exception.

As such the relief that would be available would be either the prospective reenrollment of the Appellant into his coverage or the retro enrollment of the Appellant going back to the February 2024. In either case, the Appellant would be responsible for applicable premiums. HSRI already offered such a remedy to the Appellant and reiterated that such a remedy was still available at the hearing. Considering the existing offer by HSRI, there is no remedy this tribunal can provide that is not already being provided by HSRI.

CONCLUSION OF LAW

After careful review of the testimony and evidence present at the administrative hearing, this Appeals Officer concludes:

1. Having HSRI cover the cost of the Appellant's health insurance for February and March is not permitted under policy. Such a remedy, if it exists, falls under principals of equity which are outside the scope of this trihunal.
2. The Appellant needs to apply for an exception with HSRI and have HSRI decided on the application before this tribunal can rule on the matter.
3. The available remedy is either prospective or retroactive re-enrollment of the Appellant into his health coverage. HSRI has already made this remedy available to the Appellant.

DECISION

Based on the foregoing findings of fact, conclusions of law, evidence, and testimony it is found that a final order be entered that the relief being sougbt by the Appellant is outside the jurisdiction of this tribunal to grant.

APPEAL DISMISSED

/s/ Shawn J. Masse

Shawn J. Masse

Appeals Officer

NOTICE OF APPELLANT RIGHTS

This hearing decision constitutes a final order pursuant to R.I.G.L. § 42-35-12. An appellant may seek judicial review to the extent it is available by law. 45 C.F.R. § 155.520 grants appellants who disagree with the decision of a State Exchange appeals entity, the ability to appeal to the U.S. Department of Health and Human Services (HHS) appeals entity within thirty (30) days of the mailing date of this decision. The act of filing an appeal with HHS does not prevent or delay the enforcement of this final order. You can file an appeal with HHS at https://www.healthcare.gov/downloads/marketplace-appeal-request-form-a.pdf or by calling 1.800.318.2596.

This final order constitutes a final order of the Department of Human Services pursuant to R.I.G.L. § 42-35-12. Pursuant to R.I.G.L. § 42-35-15, a final order may be appealed to the Superior Court sitting in and for the county of Providence within thirty (30) days of the mailing date of this decision. Such appeal, if taken, must be completed by filing a petition for review in Superior Court. The filing of the complaint does not itself stay enforcement of this order. The agency may grant, or the reviewing court may order, a stay upon the appropriate terms.

CERTIFICATION

I hereby certify that I mailed, via regular mail, postage prepaid, a true copy of the foregoing to [redacted]; copies were sent, via email, to [redacted], Ben Gagliardi, Esq., Mary Laurila, Vianchell Tiburcio, and Lindsay Lang on this 17th day of July, 2024.