STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 30, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027629

[redacted]

Dear [redacted],

On March 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 21, 2017 disenrollment notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: March 30, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027629

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that your enrollment in your qualified health plan (QHP) ended effective January 31, 2018?

Procedural History

On November 9, 2017, NYSOH issued a renewal notice stating that it was time to renew your health insurance coverage for 2018. The notice further stated that you were eligible to receive up to $309.39 per month in advance payments of the premium tax credit (APTC), and eligible for cost-sharing reductions if you enrolled in a silver level QHP, effective January 1, 2018. The notice also stated that NYSOH had reenrolled you into your Healthfirst bronze level QHP with family dental and vision coverage, which was the plan you were enrolled in for 2017. Finally, the notice stated that you could confirm or change the amount of tax credit applied to your monthly premium by logging into your account and updating your tax credit after November 15, 2017.

On November 18, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in your Healthfirst bronze plan, with family dental and vision coverage, with a monthly premium of $195.79, after the application of $251.00 in APTC, beginning January 1, 2018.

On December 21, 2017, NYSOH issued a notice stating that your enrollment in your Healthfirst bronze level QHP with family dental and vision coverage was

ending, effective January 31, 2018 because you asked for your coverage to end on December 20, 2017.

Also on December 21, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Healthfirst bronze level plan with pediatric dental coverage and a monthly premium of $122.38 per month, after the application of your $309.39 APTC, beginning February 1, 2018.

On January 23, 2018, you contacted the NYSOH Account Review Unit and appealed the date you were disenrolled from your Healthfirst bronze level QHP with family dental and vision coverage, requesting the disenrollment be made effective January 1, 2018.

On March 13, 2018, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the proceeding.

Findings of Fact

A review of the record supports the following findings of fact:

1) Your NYSOH account reflects that you originally became eligible to receive APTC effective November 1, 2017.

2) You testified, and your NYSOH account reflects, that you were enrolled in a Healthfirst bronze plan in November and December 2017.

3) You testified that, when you enrolled in coverage originally, you were told how much of a subsidy you were eligible for, and what your monthly premium would be.

4) You testified that you contacted NYSOH in December 2017 to enroll in a plan because you had been informed by your health plan that your current coverage was ending as of January 1, 2018.

5) You testified that you were told by the person you spoke with in December 2017 that your coverage would not begin until February 1, 2018, so you canceled your medical appointments that you had scheduled for January 2018.

6) You testified that you do not recall receiving the November 9, 2017 renewal notice which stated that you were eligible to receive up to $303.39 per month in APTC, and that you were being reenrolled into your Healthfirst bronze plan.

7) You testified that you do recall receiving the November 18, 2017 enrollment confirmation notice informing you that you were enrolled in your Healthfirst QHP as of January 1, 2018, but that you did not realize that the amount of APTC applied was not the full amount of your tax credit.

8) You testified that you received a bill from your plan in January 2018 that was for a higher premium amount, so you called your QHP, who in turn advised you to contact NYSOH.

9) You testified that you then contacted NYSOH and were told that the full amount of your APTC was not applied to your monthly premium.

10) You testified that, even though you did not think you had coverage for January 2018, you ended up paying the $180.00 or $190.00 premium because your health plan told you that you could lose your coverage if you did not.

11) You testified that you also ended up being reenrolled into a plan with no dental coverage, which you did not ask for, but that you are content with that coverage at this point.

12) You testified that you want to be reimbursed for the premium you paid in January 2018 because you were unable to use the coverage.

13) After the hearing, the Hearing Officer requested the recording of any phone calls you had with NYSOH on December 20, 2017 (the day you selected your current plan for enrollment). The following findings of fact are taken from the recording of your call with NYSOH's customer service on that date:

    a. You informed the NYSOH agent that you were calling because the cost of your health insurance coverage had gone up by $50.00 for January 2018, and you wanted to cancel your coverage if you could because you could not afford the new premium amount;
    b. The NYSOH representative told you that she would see what was occurring with your coverage, and pulled up your NYSOH account;
    c. The NYSOH representative told you that you were eligible for a tax credit of $309.00, but that the full amount was not being applied to your premium;
    d. The NYSOH agent asked you if you wanted to apply the full amount of APTC to your premium, and you said "yes;"
    e. The NYSOH agent asked if you wanted to be enrolled in the same plan, and you said "yes;"

f. The NYSOH agent told you that your premium amount would be $122.38, and provided you with a transaction number of [redacted].”
g. The NYSOH agent informed you that your insurer would follow up with you regarding payment of your premium, and that they would receive information regarding the new amount of tax credit being applied to your subsidy;
h. The NYSOH agent did not mention a start date of your new premium;
i. You did not discuss any dates or ask any questions regarding the start date of your coverage with the NYSOH agent.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Termination of a Qualified Health Plan

NYSOH must permit an enrollee to terminate his or her coverage with a QHP with appropriate notice to the NYSOH or QHP (45 CFR § 155.430(b)(1)(i)).

For enrollee-initiated terminations, the last day of coverage is either:

1) The termination date specified by the enrollee, if the enrollee provides reasonable notice (at least 14 days before the requested termination date);

2) Fourteen days after the enrollee requests the termination, if they do not provide reasonable notice; or

3) On a date on or after the date the enrollee requests the termination, if the enrollee’s QHP issuer and the enrollee agree to such a date

(45 CFR § 155.430(d)(2)(i)-(iii)).

NYSOH must permit an enrollee to retroactively terminate or cancel their enrollment in a QHP if:

1) The enrollee demonstrates that they attempted to terminate their coverage and experienced a technical error that did not allow the coverage to be terminated, and requests retroactive termination within 60 days after they discovered the technical error.

2) The enrollment in the QHP was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of NYSOH or HHS, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment.

3) The enrollee was enrolled in a QHP without their knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

(45 CFR § 155.430(b)(2)(iv)(A-C)).

NYSOH permits a QHP to terminate an individual's coverage if (1) the enrollee is no longer eligible for coverage or (2) non-payment of the premiums by the enrollee (45 CFR § 155.430(b)(2)(i)-(ii)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your Healthfirst bronze level QHP with family dental and vision coverage ended effective January 31, 2018.

On November 9, 2017, NYSOH issued a renewal notice stating that you were eligible to receive up to $309.39 per month in APTC, and eligible for cost-sharing reductions if you enrolled in a silver level QHP, effective January 1, 2018.

On November 18, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Healthfirst QHP with family dental and vision coverage and a monthly premium of $195.79, beginning January 1, 2018.

On December 21, 2017, NYSOH issue a disenrollment notice indicating you would be disenrolled from your Healthfirst bronze level QHP with family dental and vision coverage, effective January 31, 2018. That same day, an enrollment confirmation notice was issued stating that you were enrolled in a Healthfirst bronze level QHP with pediatric dental coverage, effective February 1, 2018.

You testified that you are seeking retroactive disenrollment from your Healthfirst bronze level QHP with family dental and vision coverage, effective January 1, 2018, because you were unable to use the coverage, as NYSOH allegedly told you that you would not have any coverage in the month of January 2018.

NYSOH must permit an enrollee to be retroactively disenrolled from their QHP if the enrollee demonstrates that there was a technical error that should have

allowed them to terminate coverage earlier, or if their enrollment in the plan was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of NYSOH, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities, or the enrollee was enrolled into a QHP without their knowledge or consent by a third party.

It is first noted that, according to your testimony, and as confirmed by the recording of your phone call with NYSOH on December 20, 2017, you did not actually request to be disenrolled from your Healthfirst bronze level QHP with family dental and vision. The record reflects that you were disenrolled from this coverage when you called to find out why your premium had increased. During the call, the NYSOH agent appears to have mistakenly changed your coverage from one Healthfirst bronze plan to another when she made changes to the amount of APTC applied to your monthly premium. However, as you have testified that you now wish to remain in the new plan that went into effect as of February 1, 2018, the disenrollment remains in place, and the only issue addressed here is whether you may request retroactive disenrollment for the month of January 2018 from your prior QHP.

There is no indication in the record that your enrollment in a QHP, as confirmed in the November 18, 2017 enrollment notice was unintentional, inadvertent, or erroneous. Furthermore, there is no indication that your enrollment in a QHP, as confirmed in the November 18, 2017 enrollment notice, was without your knowledge or consent.

You testified that you did not know that you had coverage in January 2018 because, when you called in December 2017, you were told that your enrollment would not begin until February 1, 2018. However, a review of that phone call reveals that the NYSOH agent did not discuss any start dates of coverage with you, nor did she tell you that you would not have coverage in January 2018. You told the NYSOH agent that you were calling because your premium amount for January 2018 had gone up, and you could not afford the new amount. The NYSOH agent updated the amount of APTC being applied to your monthly premium, and informed you that your health plan would be informed of the change, and would contact you regarding the new premium amount.

At no time during the call did you ask whether you would have coverage in January 2018, and at no point did the NYSOH agent tell you that you would not have coverage in January 2018. Therefore, there is no indication in the record that your enrollment in a QHP for January 2018 was the result of the error or misconduct of an officer, employee, or agent of NYSOH, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities.

As such, there is no basis to find that NYSOH must permit you to retroactively terminate or cancel your enrollment in a QHP.

The record reflects that on January 23, 2018, you contacted NYSOH and requested that you be disenrolled from your QHP for the month of January 2018, and you filed an appeal when your request was denied.

Enrollees must be allowed to terminate their coverage with a QHP at the date they specify if they provide reasonable notice to NYSOH or to their health plan. Reasonable notice is defined as at least 14 days prior to the requested termination date.

NYSOH terminated your insurance coverage with your QHP effective January 31, 2018, which was the last day of the month following the changes that were made to your account on December 20, 2017.

Since you do not qualify to be retroactively disenrolled from your coverage and you did not provide reasonable notice to NYSOH for a December 31, 2017 end date, NYSOH properly determined that your disenrollment in your QHP was effective January 31, 2018

Therefore, the December 21, 2017 disenrollment notice is AFFIRMED.

Decision

The December 21, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: March 30, 2018

How this Decision Affects Your Eligibility

This decision does not change your disenrollment date. Your enrollment in your Healthfirst bronze level QHP with family dental and vision coverage ended as of January 31, 2018.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Summary

The December 21, 2017 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your Healthfirst bronze level QHP with family dental and vision coverage ended as of January 31, 2018.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

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Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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