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

Notice of Decision

Decision Date: May 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015517

[redacted]

Dear [redacted],

On May 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 3, 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
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Decision

Decision Date: May 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015517

[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, and your child's, enrollment in your qualified health plan (QHP) ended effective February 28, 2017?

Procedural History

On December 14, 2016, you created a NYSOH account and filed an application for financial assistance with health insurance on behalf of yourself and your child.

On December 15, 2016, NYSOH issued a notice of eligibility determination stating that you and your child were eligible to receive up to $434.00 per month in advance payments of the premium tax credit (APTC), effective January 1, 2017.

Also on December 15, 2016, NYSOH issued a notice of enrollment confirmation, confirming your, and your child's, enrollment in a bronze-level family QHP through Fidelis Care, with an enrollment start date of January 1, 2017. The notice stated that your monthly premium was $189.96, after the application of your APTC, and that your deductible was $8,000.00 for your family.

On December 16, 2016, NYSOH issued a disenrollment notice, stating that your, and your child's, coverage in your Fidelis Care QHP would end effective January 1, 2017 because you requested to end this coverage on December 15, 2016.

Also on December 16, 2016, NYSOH issued a notice of enrollment confirmation, confirming your, and your child's, enrollment in a bronze-level family QHP through Healthfirst, with an enrollment start date of January 1, 2017. The notice stated that your monthly premium was $239.03, after the application of your APTC, and that your deductible was $8,000.00 for your family.

On February 2, 2017, you updated your NYSOH account and changed your application to state that you and your child did not need health insurance.

On February 3, 2017, NYSOH issued a discontinuance notice stating that you and your child were not qualified to enroll in coverage through NYSOH, effective March 1, 2017, because you no longer wanted coverage.

Also on February 3, 2017, NYSOH issued a disenrollment notice stating that your, and your child's, enrollment in your Healthfirst QHP would end effective February 28, 2017 because you were no longer eligible to enroll in health insurance through NYSOH.

That same day, you contacted the NYSOH Account Review Unit and appealed the date you and your child were disenrolled from your QHP, requesting the disenrollment be made effective January 1, 2017.

On May 3, 2017, 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 hearing.

Findings of Fact

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

1) You testified, and your account confirms, that you applied for health insurance for yourself and your child in December 2016.

2) You testified that you wanted to be sure that you and your child had medical, dental, and vision coverage; so, after you chose a Fidelis Care plan for enrollment, you called NYSOH to make sure that the plan you had selected included dental and vision coverage.

3) You testified that you spoke with someone at NYSOH who told you that the plan you had selected did not include dental and vision coverage, so you reviewed the available plans with him and then selected a Healthfirst plan that covered medical, dental, and vision.

4) You testified that you do not recall discussing any costs other than the monthly premium amount, and that you do not believe the issue of deductibles came up during this conversation.

5) You testified that, when you tried to make an appointment in January 2017, you were told by the office staff of the medical office that you had a very high deductible, and that you would be responsible for all costs for the visit.

6) You testified that, at that point, you began calling Healthfirst and NYSOH, and kept being referred by one to call the other.

7) You testified that you decided you were going to cancel the coverage, since the costs were not going to be feasible, between the monthly premiums and the deductible.

8) You testified that you had already paid the January 2017 premium, so you contacted Healthfirst to try to get that payment refunded, but Healthfirst would not refund the premium.

9) You testified that you asked NYSOH about switching to a plan with a lower deductible, but were told that would not be an option until 2018.

10) After the hearing, the Hearing Officer listened to a recording of your December 15, 2016 phone call with NYSOH in its entirety. During that conversation, you requested to change to a plan that included dental and vision coverage, and selected a Healthfirst bronze plan. Though you asked the NYSOH representative whether this was a "good" plan, you did not ask any questions about deductibles or other costs associated with the plan.

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 NYSOH or the 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, and your child's, enrollment in your QHP ended effective February 28, 2017.

On December 16, 2016, NYSOH issued an enrollment confirmation notice stating that you and your child were enrolled in a QHP, and that your APTC was being applied to your monthly premium, effective January 1, 2017.

On February 3, 2017, NYSOH issue a disenrollment notice indicating you and your child would be disenrolled from your QHP effective February 28, 2017.

You testified that you are seeking retroactive disenrollment from your QHP for yourself and your child, effective January 1, 2017.

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.

There is no indication in the record that your enrollment in a QHP, as confirmed in the December 16, 2016 enrollment notice, was unintentional, inadvertent, or erroneous, nor was your enrollment in a QHP 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. Furthermore, there is no indication that your enrollment in a QHP as confirmed in the December 16, 2016 enrollment notice was without your knowledge or consent. Though you testified that you did not know about the deductible, you also testified, and the recording of your phone conversation with NYSOH on December 15, 2016 confirms, that you did not ask NYSOH about the deductible when you selected your Healthfirst bronze plan.

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

The record reflects that on February 2, 2017, you contacted NYSOH and requested that you and your child be disenrolled from your QHP, as you no longer wanted to remain enrolled.

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 February 28, 2017, which is the last day of the month following your request.

Since you do not qualify to be retroactively disenrolled from your coverage and you did not provide reasonable notice to NYSOH, NYSOH properly determined that your, and your child's, disenrollment in your QHP was effective as of February 28, 2017.

Therefore, the February 3, 2017 disenrollment notice is AFFIRMED.

Decision

The February 3, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: May 12, 2017

How this Decision Affects Your Eligibility

You are not eligible to have your QHP coverage terminated retroactively.

Your, and your child's, enrollment in your QHP properly ended on February 28, 2017.

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

Summary

The February 3, 2017 disenrollment notice is AFFIRMED.

You are not eligible to have your QHP coverage terminated retroactively.

Your, and your child's, enrollment in your QHP properly ended on February 28, 2017.

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 निःशुल्क 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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