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

Notice of Decision

Decision Date: September 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019191

[redacted]

Dear [redacted],

On August 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 31, 2017 disenrollment from your health plan.

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
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Decision

Decision Date: September 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019191

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determined that your enrollment in your qualified health plan ended effective May 31, 2017?

Procedural History

On April 10, 2017, NYSOH received your application for health insurance.

On April 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective May 1, 2017. The notice stated you must confirm your health plan selection by June 9, 2017.

On April 11, 2017, NYSOH issued an enrollment notice confirming your enrollment on April 10, 2017, in a Platinum level qualified health plan for a cost of $657.77 per month, effective May 1, 2017.

On May 11, 2017, NYSOH redetermined your eligibility.

On May 12, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective June 1, 2017. It further stated that you do not qualify to select a health plan outside of the open enrollment period for 2017.

On May 23, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as you were not eligible to enroll in a health plan outside of the open enrollment period for 2017.

On June 20, 2017, you updated your NYSOH account and an application was submitted on your behalf.

On June 21, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective June 1, 2017.

On June 21, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan as of August 1, 2017.

On July 12, 2017, your qualified health plan initiated termination of your plan back to May 31, 2017 because you were eligible for Medicaid.

On August 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During that hearing you testified you were appealing the termination date of your qualified health plan and requested a refund for your health plan you were enrolled in for May, 2017. 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) The record supports you enrolled in a platinum level health plan with Healthfirst, through your online account on April 10, 2017.

2) You testified your online ID is [redacted].

3) You testified your doctor only accepts HealthPlus.

4) You testified you became aware that your doctor only accepts HealthPlus after speaking with him and attempted to contacted NYSOH on May 11, 2017 to change your plan to HealthPlus.

5) You testified that you were not sure of the date you contacted NYSOH to request disenrollment from your qualified health plan through NYSOH.

6) The record shows you became eligible for insurance through Medicaid as of June 1, 2017.

7) The record supports on June 20, 2017, a NYSOH representative disenrolled you from your qualified health plan.

8) You testified that you paid a premium to your qualified health plan Healthfirst for the month of May 1, 2017, in the amount of $657.77.

9) You testified that you did not use your qualified health plan in the month of May, 2017.

10) You testified that you are seeking retroactive disenrollment from your qualified health plan effective May 1, 2017, and a refund of the premium you paid to that plan.

11) You reside in [redacted] NY.

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 qualified health plan coverage, with appropriate notice to the NYSOH or qualified health plan (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 qualified health plan 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 qualified health plan 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 qualified health plan 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 qualified health plan 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 qualified health plan 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)).

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your qualified health plan ended effective May 31, 2017.

You testified that you are appealing the date which you were terminated from your qualified health plan, requesting that instead of May 31, 2017, it be May 1, 2017, and that your insurance premium you paid for that month be refunded to you. However, the record does not contain a notice of disenrollment showing the date by which you were officially disenrolled from your qualified health plan.

Here, the lack of a notice of disenrollment on the issue of special enrollment periods does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

Your credible testimony along with the NYSOH account enrollment history screen confirms that your disenrollment from your qualified health plan was effective May 31, 2017. Your testimony at the time of your hearing requesting a refund for the month of May, 2017, for the premium you paid for that month, as well as your NYSOH account permits an inference that NYSOH did deny you an earlier termination date than May 31, 2017.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the disenrollment notice had it been issued.

On April 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost effective May 1, 2017. That same day an enrollment confirmation notice was issued confirming your enrollment in a Platinum level qualified health plan effective May 1, 2017.

The record supports you then became eligible for Medicaid effective June 1, 2017, and were disenrolled from your qualified health plan on June 20, 2017, effective May 31, 2017.

You testified that you are seeking retroactive disenrollment from your qualified health plan effective May 1, 2017.

NYSOH must permit an enrollee to be retroactively disenrolled from their qualified health plan 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 qualified health plan without their knowledge or consent by a third party.

There is no indication in the record that your enrollment in a qualified health plan as confirmed in the April 11, 2017 enrollment notice was unintentional, inadvertent, or erroneous, nor was your enrollment in a qualified health plan 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 qualified health plan as confirmed in the April 11, 2017, enrollment notice was without your knowledge or consent.

The record supports you submitted the enrollment online using your ID name of [redacted] on April 10, 2017. Since you submitted the enrollment, there was no role by a NYSOH representative in the act of your selection of the health plan you enrolled in that day.

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

You testified you were not sure the date you contacted NYSOH to request retro disenrollment from your qualified health plan. The earliest date in the record is a contact on May 11, 2017 in which you requested to change your health plan but were denied a special enrollment period to do so as evident in the May 12, 2017, eligibility determination notice.

Enrollees must be allowed to terminate their coverage with a qualified health plan 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 qualified health plan effective May 31, 2017, which is the last day of the month following your May 11, 2017 contact.

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 disenrollment in your qualified health plan was effective May 31, 2017.

Therefore, the May 31, 2017 disenrollment is AFFIRMED.

Decision

The May 31, 2017 disenrollment is AFFIRMED.

Effective Date of this Decision: September 6, 2017

How this Decision Affects Your Eligibility

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of May 31, 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

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).

The May 31, 2017 disenrollment is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of May 31, 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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.

□□□□□ (Bengali)

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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)

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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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