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

Notice of Decision

Decision Date: February 06, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024191

[redacted]

[redacted]

On January 29, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 7, 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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Decision

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NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024191

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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 November 30, 2017?

Procedural History

On November 16, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a QHP at full cost, effective January 1, 2017.

On December 3, 2016, NYSOH issued an enrollment notice confirming your enrollment in an MVP platinum level QHP with a $778.31 per month premium, beginning January 1, 2017.

On October 17, 2017, NYSOH issued a renewal notice stating that it was time to renew your application for health insurance through NYSOH. The notice stated that you needed to update the information in your application between November 16, 2017 and December 15, 2017 so that a decision could be made about your eligibility.

On November 6, 2017, you updated your application for financial assistance and uploaded documentation to your NYSOH account.

On November 7, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH obtained

from federal and state data sources. The notice directed you to submit documentation of your income by November 21, 2017.

Also on November 7, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in your QHP would end effective November 30, 2017.

That same day, you uploaded documentation to your NYSOH account.

On November 8, 2017, your eligibility was redetermined.

On November 9, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective November 1, 2017.

Also on November 9, 2017, you contacted the NYSOH Account Review Unit and appealed the date you were disenrolled from your QHP, requesting the disenrollment be made effective October 31, 2017.

On November 10, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Medicaid Managed Care (MMC) plan, beginning December 1, 2017.

On January 29, 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 were enrolled in a QHP at full cost through NYSOH, and that your coverage was effective as of January 1, 2017.

2) You testified that you spoke with NYSOH's customer service center around the time you updated your account on November 6, 2017 because you knew that your renewal period was approaching.

3) You testified that you were told by NYSOH that you should apply by November 15, 2017 to have Medicaid coverage for December 1, 2017.

4) You testified that you were not aware that if you were approved for Medicaid, you would receive Fee-For-Service Medicaid immediately, and you feel you were misinformed in this regard.

5) You testified that you thought you would begin to receive Medicaid as of December 1, 2017, not November 1, 2017, and only found out later that your MMC plan would begin on December 1, but not your Fee-For-Service Medicaid.

6) Your NYSOH account reflects that you were found eligible for Medicaid as of November 1, 2017, and enrolled into an MMC plan as of December 1, 2017.

7) You testified that you paid your full premium for November 2017 and would like to be reimbursed, as you do not want double coverage for that month.

8) You testified that you might have waited until a later date to apply for financial assistance if you had known that there would be an overlap in coverage.

9) You testified that you may have used your QHP in the month of November 2017 to fill prescriptions.

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)).

If an enrollee is newly eligible for Medicaid, the last day of coverage for the QHP is the day before the Medicaid coverage begins (45 CFR § 155.430(d)(2)(iv)).

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 QHP ended effective November 31, 2017.

On November 16, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a QHP at full cost, effective January 1, 2017. You subsequently enrolled into a QHP.

You testified that you are seeking retroactive disenrollment from your QHP, effective October 31, 2017, so that you do not have an overlap in coverage.

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 3, 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 3, 2016 enrollment notice was without your knowledge or consent.

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

On October 17, 2017, NYSOH issued a renewal notice informing you that you needed to update your application for financial assistance between November 16, 2017 and December 15, 2017 to avoid a gap in coverage. On November 6, 2017, you contacted NYSOH to update your application for financial assistance. You testified that you did this because you wanted to be eligible for Medicaid, and you were told by NYSOH that you should apply by November 15, 2017 to have Medicaid coverage by December 1, 2017. As a result, you were found eligible for Medicaid effective November 1, 2017. On November 7, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your QHP would end effective November 30, 2017.

You testified that you are seeking an earlier disenrollment date because you had Medicaid coverage in November 2017, when you were still enrolled in your QHP, and that you do not want overlapping coverage, and would like to be reimbursed for the QHP premium you paid for the month of November 2017.

If an enrollee is newly eligible for Medicaid, the last day of coverage through their QHP is the day before the Medicaid coverage begins. Since you were determined eligible for Medicaid on November 9, 2017, under the regulations your QHP should have terminated that day. However, NYSOH does not allow for prorated or partial premiums based on the amount of days in a month you were enrolled in a QHP. As such, your plan was terminated at the end of the calendar month in which you became eligible for Medicaid.

Therefore, NYSOH properly determined that your plan terminated as of November 30, 2017, and NYSOH’s November 7, 2017 disenrollment notice is AFFIRMED.

Decision

The November 7, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: February 06, 2018

How this Decision Affects Your Eligibility

This decision does not change your disenrollment date. Your enrollment in your QHP ended as of November 30, 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 November 7, 2017 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your QHP ended as of November 30, 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 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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