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

Notice of Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026477

[redacted]

Dear [redacted],

On March 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 2, 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
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Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026477

[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 1, 2018?

Procedural History

On November 7, 2017, you updated your application for financial assistance with health insurance through NYSOH.

On November 8, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $184.00 per month in advance payments of the premium tax credit (APTC), effective December 1, 2017.

On November 15, 2017, NYSOH issued an enrollment notice confirming your enrollment in a QHP with a monthly premium of $183.04, after the application of your $184.00 in APTC, beginning December 1, 2017.

On December 1, 2017 income information in your NYSOH account was updated, and you uploaded documentation to your NYSOH account.

On December 2, 2017, NYSOH issued a notice stating that the income information in your application did not match the information NYSOH received from federal and state data sources, and that you needed to provide documentation of your income by December 16, 2017.

Also on December 2, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in your QHP would end, effective January 1, 2018, because you were no longer eligible to remain enrolled in that plan.

On December 5, 2017, NYSOH issued a notice stating that the income documentation you provided was not sufficient to confirm the information in your application. The notice directed you to provide income documentation by December 16, 2017.

On December 6, 2017, you uploaded additional documentation to your NYSOH account, and NYSOH redetermined your eligibility.

On December 7, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective December 1, 2017.

Also on December 7, 2017, NYSOH issued a notice of enrollment, confirming your enrollment in a Medicaid Managed Care plan, beginning January 1, 2018.

On December 29, 2017, you contacted the NYSOH Account Review Unit and appealed the date you were disenrolled from your QHP, requesting the disenrollment be made effective December 1, 2017.

On March 8, 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) The record reflects that you were enrolled in a QHP through NYSOH, and that your coverage was effective as of December 1, 2017.

2) You testified, and your NYSOH account confirms, that you were previously enrolled in Medicaid prior to December 2017.

3) You testified that you were working a long term temporary job, so you updated your NYSOH application in November 2017 because you knew that you could afford to contribute toward the cost of your health insurance.

4) You testified that you paid the premium for the December 2017 QHP coverage in November 2017.

5) You testified that, on November 22, 2017, the job you had been working ended without much advance notice.

6) You testified that you updated your application again, and were found eligible for Medicaid.

7) Your NYSOH account confirms that, on December 1, 2017 you updated your application, and you were found eligible for Medicaid in a notice dated December 7, 2017, with your eligibility beginning December 1, 2017.

8) You testified that, once you found out that your Medicaid coverage was going to start in December, you called your QHP and asked about being disenrolled from coverage and reimbursed for your premium, but were told that you needed to call NYSOH.

9) You testified that, after that, you spent many hours on the phone with NYSOH and your plan trying to get the issue resolved, but were unable to get your disenrollment changed to December 1, 2017.

10) You testified that you did not use the QHP coverage at all in December 2017, and that the one medical appointment you went to in that month was covered by Medicaid.

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 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 January 1, 2018.

On November 8, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $184.00 per month in APTC, effective December 1, 2017. You subsequently enrolled into a QHP.

You testified that you are seeking retroactive disenrollment from your QHP, effective December 1, 2017, because you became eligible for Medicaid, and that eligibility began on December 1, 2017.

NYSOH must permit an enrollee to be retroactively disenroll 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 November 15, 2017 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 November 15, 2017 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 December 1, 2017, you contacted NYSOH to update your application for financial assistance. As a result, you were placed into a “pending Medicaid status,” and were then found eligible for Medicaid, effective December 1, 2017. On December 2, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your QHP would end effective January 1, 2018.

You testified that you are seeking an earlier disenrollment date because you had Medicaid coverage in December 2017, when you were still enrolled in your QHP, and you would like to be reimbursed for the premium payment you made for the December QHP coverage.

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 December 7, 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 and, 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 January 1, 2018, and NYSOH’s December 2, 2017 disenrollment notice is AFFIRMED.

Decision

The December 2, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: March 14, 2018

How this Decision Affects Your Eligibility

This decision does not change your disenrollment date. Your enrollment in your QHP ended as of January 1, 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

Summary

The December 2, 2017 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your QHP ended as of January 1, 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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