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: AP000000027515

[redacted]

Dear [redacted],

On March 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 20, 2018 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 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027515

[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 ended effective February 28, 2018?

Procedural History

On August 23, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for up to $368.00 per month in advance payment of the premium tax credit (APTC) and cost-sharing reductions if you enrolled in a silver level qualified health plan, effective October 1, 2017.

Also on August 23, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a qualified health plan with a plan enrollment start date of September 1, 2017.

On October 28, 2017, NYSOH issued a renewal notice stating that you were eligible for up to $410.64 per month in APTC and cost-sharing reductions if you enrolled in a silver level qualified health plan, effective January 1, 2018. This notice also stated that you had been re-enrolled into the same plan that you previously had.

On November 18, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a qualified health plan with a plan enrollment start date of January 1, 2018.

On January 19, 2018, you contacted NYSOH and requested to disenroll from your qualified health plan.

Also on January 19, 2018, you spoke to NYSOH's Account Review Unit and appealed the date you were disenrolled from your qualified health plan, requesting the disenrollment be made effective September 1, 2017.

On January 20, 2018, NYSOH issued a disenrollment notice stating that your coverage in your qualified health plan would end on February 28, 2018. This was because you had requested to end your coverage.

On February 22, 2018, NYSOH issued a notice of telephone hearing stating that your hearing was scheduled for March 8, 2018 at 3:00 pm.

On March 8, 2018, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. Under oath, you waived your right to timely notice of the hearing. 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 the first application for financial assistance submitted on your behalf was submitted September 1, 2016 by a certified application counselor. In this application, the automatic renewal option was selected. As a result of this application, you were found eligible for Medicaid, effective September 1, 2016.

2) You testified that you contacted a certified application counselor in 2016 as you had been laid off from work and needed coverage for a [redacted].

3) You testified that in August 2017 you contacted the same certified application counselor as you learned that your Medicaid was ending as of August 31, 2017.

4) You testified that the certified application counselor informed you that you were no longer eligible for Medicaid and that you would be responsible for paying a premium for your health insurance. You testified that at that time, you told the certified application counselor that you did not want to continue coverage through NYSOH.

5) Your NYSOH account reflects that on August 22, 2017, a certified application counselor updated your application for financial assistance

with health insurance. In that application, the automatic renewal option was selected. As a result of this application, you were found eligible for APTC of up to $368.00 per month.

6) You testified that you do not believe you told the certified application counselor to select autoenrollment, as you were declining to continue coverage through NYSOH.

7) On August 22, 2017, a certified application counselor enrolled you in a qualified health plan with a monthly premium of $337.31, to which APTC of $337.31 was applied, resulting in a $0.00 premium responsibility.

8) You testified that you never received insurance cards or any bills from your qualified health plan for 2017 coverage. It was not until you received a premium bill for January 2018 that you realized that you had been enrolled in coverage.

9) Your NYSOH account reflects that on January 19, 2018, you contacted NYSOH to disenroll yourself from your qualified health plan through NYSOH.

10) You testified that you have never paid a premium to your qualified health plan.

11) You testified that you have never used your qualified health plan.

12) You testified, and the record reflects, that you receive all of your notices from NYSOH via regular mail.

13) You testified that you did not recall receiving the August 23, 2017 enrollment confirmation notice stating that you had been enrolled in a qualified health plan effective September 1, 2017, the October 28, 2017 renewal notice stating that you had been enrolled in a qualified health plan effective January 1, 2018, or the November 18, 2017 enrollment notice stating that you had been enrolled in a qualified health plan effective January 1, 2018.

14) No notices that were sent to the address listed on your NYSOH account have been returned as undeliverable.

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

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

Applicable Law and Regulations

Annual Eligibility Redetermination

Generally, NYSOH must conduct annual eligibility redeterminations for qualified individuals who are seeking financial assistance through insurance affordability programs for the upcoming year, such as tax credits and cost-sharing reductions, Medicaid, or Child Health Plus. In such cases, NYSOH is required to request that the qualified individual provide updated income and family size information for use in an eligibility redetermination for the upcoming year (*see* 45 CFR § 155.335(a) and (b)).

NYSOH must send an annual renewal notice that contains the information by which NYSOH will use to redetermine a qualified individual's projected eligibility for that year (45 CFR § 155.335(c)(3)). If a qualified individual does not respond to the notice after a 30-day period, NYSOH must redetermine that individual's eligibility using the information and projected eligibility provided in the annual renewal notice (45 CFR § 155.335(g), (h)). NYSOH must ensure this redetermination is effective on the first day of the coverage year or in accordance with the rules specified in 45 CFR § 155.330(f) regarding effective dates, whichever is later (45 CFR § 155.335(i)). The rules specified in 45 CFR § 155.330(f) are not pertinent here.

Annual Re-enrollment into a Qualified Health Plan

If an enrollee remains eligible for enrollment in a qualified health plan as part of the annual eligibility redetermination and the plan in which they are enrolled remains available through NYSOH for renewal, such enrollee will have his or her enrollment through the qualified health plan renewed, unless an enrollee voluntarily terminates coverage (45 CFR § 155.335(j)(1)).

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 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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your qualified health plan ended effective February 28, 2018.

On August 23, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for up to $368.00 per month in APTC effective October 1, 2017. You subsequently enrolled into a qualified health plan, effective September 1, 2017.

On January 20, 2018, NYSOH issue a disenrollment notice indicating you would be disenrolled from your qualified health plan effective February 28, 2018.

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

NYSOH must permit an enrollee to be retroactively disenroll 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, so long as the enrollee requests cancellation within 60 days of discovering the enrollment.

Although you testified that you told the certified application counselor in August 2017 that you did not want to continue to enroll in coverage through NYSOH because you would have to pay a premium for insurance, the record reflects that you were not responsible for a premium payment for 2017 as you were enrolled into a qualified health plan with a premium cost which was less than the amount of APTC for which you were found eligible. Therefore, your testimony on this matter is found lacking in credibility.

Additionally, the August 23, 2017 enrollment confirmation notice which was sent to you at the mailing address on file, alerted you to the fact that you were enrolled in a qualified health plan with a $0.00 premium responsibility effective September 1, 2017.

Although you testified that you did not receive this notice, you testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. There is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of your enrollment in a qualified health plan with a plan enrollment start date of September 1, 2017.

You did not request disenrollment from your qualified health plan for 2017 until January 19, 2018.

As such, the record is lacking in credible evidence that your enrollment in a qualified health plan as confirmed in the August 23, 2017 enrollment confirmation notice was the result of the error or misconduct of a non-NYSOH entity providing enrollment assistance or conducting enrollment activities. Furthermore, the

credible evidence in the record does not support your contention that your enrollment in a qualified health plan as confirmed in the August 23, 2017 enrollment confirmation notice was without your knowledge or consent.

NYSOH must conduct annual eligibility redeterminations for qualified individuals who are seeking financial assistance with health insurance.

Although you testified that you do not believe that you requested that the certified application counselor select the automatic renewal option in your applications, the record reflects that this option was selected at both the time of the September 1, 2016 application submission and the August 22, 2017 application submission. As this selection was made in both applications, your testimony on this matter is found lacking in credibility.

In the October 28, 2017 renewal notice, NYSOH found you eligible for up to $410.64 per month in APTC and cost-sharing reductions if you enrolled in a qualified health plan, effective January 1, 2018.

If an enrollee remains eligible for enrollment in a qualified health plan as part of the annual eligibility redetermination and the plan in which they are enrolled remains available through NYSOH for renewal, such enrollee will have his or her enrollment through the qualified health plan renewed, unless an enrollee voluntarily terminates coverage

As you remained eligible for enrollment in a qualified health plan, NYSOH was required to reenroll you into your qualified health plan for 2018.

In the October 28, 2017 renewal notice as well as the November 18, 2017 enrollment confirmation notice, you were informed that you had been automatically renewed into your qualified health plan, effective January 1, 2018.

Although you testified that you also did not receive theses notices, there is no evidence in the record that these or any other notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of your reenrollment into a qualified health plan with a plan enrollment start date of January 1, 2018.

There is no indication in the record that your enrollment in a qualified health plan as confirmed in the November 18, 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 November 18, 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 qualified health plan.

The record reflects that on January 19, 2018 you contacted NYSOH and requested that you be disenrolled from your qualified health plan as you no longer wanted to remain enrolled.

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 February 28, 2018, 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 disenrollment in your qualified health plan was effective February 28, 2018.

Therefore, the January 20, 2018, disenrollment notice is AFFIRMED.

Decision

The January 20, 2018 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 qualified health plan ended as of February 28, 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 January 20, 2018 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of February 28, 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.

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).