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

Notice of Decision

Decision Date: April 18, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027830

[redacted]

[redacted]

On March 13, 2018, your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's December 1, 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: April 18, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027830

[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 January 1, 2018?

Procedural History

On December 6, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in a Bronze-level qualified health plan for a cost of $239.33 per month, effective January 1, 2017.

On November 30, 2017, the income information in your NYSOH account was updated.

On December 1, 2017, NYSOH issued a notice stating the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to provide proof of your current household income by December 15, 2017.

On December 1, 2017, NYSOH issued a disenrollment notice indicated the coverage in your Bronze-level qualified health plan was ending January 1, 2018. The notice stated this was because you were no longer eligible to enroll in your Bronze-level qualified health plan.

On December 12, 2017, a copy of a separation letter from your employer was uploaded to your NYSOH account (*see* Document [redacted].

On December 13, 2017, a NYSOH representative verified your supporting documentation and an application was submitted on your behalf that day.

On December 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective November 1, 2017.

On December 19, 2017, NYSOH issued a plan enrollment notice stating your Medicaid Managed Care plan would start, effective February 1, 2018.

On January 25, 2018, you contacted the NYSOH Account Review Unit and appealed the date you were disenrolled from your qualified health plan, requesting the disenrollment date be made effective November 1, 2017, not January 1, 2018.

On March 13, 2018, your authorized representative, [redacted] appeared on your behalf and 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) According to your NYSOH account, you were enrolled in a qualified health plan through NYSOH and that your coverage was effective as of January 1, 2017.

2) Your authorized representative testified that you paid premiums to your health plan for the months you had coverage. You also made premium payments for November 2017 and December 2017.

3) According to your NYSOH account, you updated your application on November 30, 2017, and after providing supporting documentation you were found eligible for Medicaid, effective November 1, 2017.

4) You were disenrolled from your qualified health plan as of January 1, 2018.

5) Your authorized representative testified that you are seeking an earlier disenrollment date because you had Medicaid coverage in November 2017, when you were still enrolled in your qualified health plan.

6) Your authorized representative testified you did not use your insurance through your qualified health plan during the months of November 2017 and December 2017.

7) Your authorized representative testified you would like your premiums refunded for the months of November and December 2017.

8) Your application states 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)).

If an enrollee is newly eligible for Medicaid, the last day of coverage for the qualified health plan 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 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)).

Medicaid

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010,13ADM-03(III)(F)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your qualified health plan ended effective January 1, 2018.

You were enrolled in a Bronze-level qualified health plan for a cost of $239.33 per month, effective January 1, 2017. Your authorized representative testified that you are seeking retroactive disenrollment from this qualified health plan to November 1, 2017, and reimbursement for the monthly premium yo paid that month and for December 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 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 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 your qualified health plan.

Individuals who are found eligible for Medicaid is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month. On November 30, 2017, you contacted NYSOH to update your application for financial assistance. The result of this application was that you would be eligible for Medicaid pending supporting income documentation. After submitting supporting documentation in the form of a letter of separation, you were found eligible for Medicaid effective November 1, 2017, the first day of the month since you were determined Medicaid eligible that month. On December 1, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your qualified health would end effective January 1, 2018.

Your authorized representative testified that you are seeking an earlier disenrollment date than January 1, 2018, requesting a disenrollment as of November 1, 2017. Your representative explained because you had Medicaid coverage in November 2017, when you were still enrolled in your qualified health plan, you would like your premiums that were paid for the months of November 2017 and December 2017 refunded as you did not use your health plan for those months.

If an enrollee is newly eligible for Medicaid, the last day of coverage through their qualified health plan is the day before the Medicaid coverage begins. Since you were determined eligible for Medicaid effective November 1, 2017 your qualified health plan 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. As such, the earliest date your coverage in the Bronze-level qualified health plan in which you were enrolled could terminate was the first day following the end of the calendar month in which you became eligible for Medicaid.

Therefore, NYSOH incorrectly determined that your plan terminated as of January 1, 2018. The December 1, 2017 disenrollment notice is MODIFIED to

comport with the first day following the end of the month in which you were determined eligible for Medicaid, which is December 1, 2017.

Your case is RETURNED to NYSOH to make the necessary changes to your enrollment with your health plan and notify you once this has been done.

Decision

The December 1, 2017 disenrollment notice is MODIFIED to comport with the first day following the end of the month in which you were determined eligible for Medicaid, which is December 1, 2017.

Your case is RETURNED to NYSOH to make the necessary changes to your enrollment with your health plan and notify you and your qualified health plan once this has been done.

Effective Date of this Decision: April 18, 2018

How this Decision Affects Your Eligibility

Your enrollment in your qualified health plan should have ended as of November 30, 2017.

Your case is being sent back to NYSOH to change your disenrollment date from your Bronze-level qualified health plan to December 1, 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 December 1, 2017 disenrollment notice is MODIFIED to comport with the first day following the end of the month in which you were determined eligible for Medicaid, which is December 1, 2017.

Your case is RETURNED to NYSOH to make the necessary changes to your enrollment with your health plan and notify you and your qualified health plan once this has been done.

Your enrollment in your qualified health plan should have ended as of November 30, 2017.

Your case is being sent back to NYSOH to change your disenrollment date from your Bronze-level qualified health plan to December 1, 2017, and to notify you and your qualified health plan accordingly.

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.

(Bengali)

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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1-855-355-5777

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)

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).

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).