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

Notice of Decision

Decision Date: April 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029082

[redacted]

[redacted]

On April 11, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 7, 2018 disenrollment notice and determination that your and your spouse's coverage would end on January 31, 2018.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029082

[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 and your spouse's enrollment in your qualified health plan ended effective January 31, 2018?

Procedural History

On December 13, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to purchase a qualified health plan at full cost, effective January 1, 2018.

Also on December 13, 2017, NYSOH issued a plan enrollment notice confirming your and your spouse's enrollment in a qualified health plan effective January 1, 2018.

On February 7, 2018, NYSOH issued a discontinuance notice, stating that you and your spouse were not qualified to enroll through NYSOH because you no longer wanted to receive coverage, effective March 1, 2018.

Also on February 7, 2018, NYSOH issued a disenrollment notice indicating that coverage in your qualified health plan would end effective February 28, 2018.

On February 20, 2018, you contacted the NYSOH Account Review Unit and appealed the date you and your spouse were disenrolled from your qualified health plan.

On April 11, 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) You testified that you started a new job on [redacted], and that your new employer offered employer-sponsored coverage.

2) You testified that, on February 10, 2018, you contacted NYSOH to disenroll you and your spouse from your qualified health plan through NYSOH. You testified that you requested a January 31, 2018 termination date, and that NYSOH advised you that you would be contacted regarding your request for a retroactive disenrollment.

3) You further testified that, when you did not hear back from NYSOH after a week and a half, you assumed that your request had been denied and submitted a premium payment to your health plan for February 2018.

4) You testified that you paid a premium to your qualified health plan for the month of February 2018.

5) You testified that you used your qualified health plan in the month of February 2018, because you thought that you had coverage for that month through NYSOH.

6) Your NYSOH account contains Incident #[redacted], which contains an entry dated February 14, 2018 at 11:06am, stating "consumer coverage retro-term to 1/31/18."

7) Your NYSOH account does not contain written notice regarding a January 31, 2018 termination date.

8) You testified that you were not aware that your request for a January 31, 2018 termination date had been granted until you were at the doctor's office [redacted] 2018.

9) You testified that you are seeking disenrollment from your and your spouse's qualified health plan effective February 28, 2018.

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

Applicable Law and Regulations

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).

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your and your spouse's enrollment in a qualified health plan ended effective January 31, 2018.

You testified that you are appealing the January 31, 2018 termination date of your and your spouse's qualified health plan coverage. However, the record does not contain a notice of disenrollment stating that your coverage would end on January 31, 2018.

Here, the lack of a notice of eligibility determination on the issue of the January 31, 2018 disenrollment 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 February 14, 2018 note in your account stating that "consumer coverage retro-term to 1/31/18," and the February 21, 2018 notice stating that the reason for your appeal was "failure of the exchange to provide timely notice of eligibility determination" for you and your spouse, permits an inference that NYSOH did terminate your and your spouse's coverage on January 31, 2018.

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

On December 12, 2017, submitted a request to enroll in a qualified health plan. On December 13, 2017, NYSOH issued a plan enrollment confirmation notice stating that you and your spouse were enrolled in a qualified health plan, effective January 1, 2018.

You testified that you began a new job on [redacted], and that your new employer offered employer-sponsored coverage. On February 6, 2018, you contacted NYSOH and indicated that you no longer needed coverage.

On February 7, 2018, NYSOH issued a disenrollment notice, stating that your and your spouse's coverage would end, effective February 28, 2018.

You testified that when you became aware of the February 28, 2018 termination date, you requested that NYSOH retroactively terminate your and your spouse's qualified health plan as of January 31, 2018.

Your account contains Incident #[redacted], which contains an entry dated February 14, 2018 at 11:06am, stating "consumer coverage retro-term to 1/31/18." Your account does not contain written notice regarding a January 31, 2018 termination date. You testified that you were not aware that your request for a January 31, 2018 termination date had been granted until you were at the doctor's office [redacted] 2018.

You testified that because you did not receive any notification or call from NYSOH regarding your request for retroactive termination, you assumed that your request had been denied and that you and your spouse would be covered for February 2018. You testified that you paid your premium for February 2018 and used your coverage that month.

A review of the complete record confirms that NYSOH did not timely make a determination regarding your request for retroactive termination and/or that you were not timely notified of the back date of your qualified health plan disenrollment to January 31, 2018, which deprived you of any significant value in having coverage retroactively terminated to January 31, 2018. You credibly testified that you were never notified that your request for a retroactive termination had been granted, that you paid the premium for that February 2018, and that you used your qualified health plan. Given the time of the month this determination was made, NYSOH should have offered you the opportunity to decline the retroactive termination before putting it in effect. Furthermore, NYSOH failed to issue a written notice to you confirming that your plan had in fact been retroactively terminated as of January 31, 2018.

The only disenrollment notice contained in the record prior to the filing of your appeal is the February 7, 2018 disenrollment notice, stating that your and your spouse's coverage in a qualified health plan would end effective February 28, 2018

Therefore, the February 7, 2018 disenrollment notice is AFFIRMED and your case is RETURNED to NYSOH to reinstate your and your spouse's coverage for February 2018, and to notify you accordingly.

Decision

The February 7, 2018 disenrollment notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate your and your spouse's coverage for February 2018, and to notify you accordingly.

Effective Date of this Decision: April 25, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate your and your spouse's qualified health plan coverage for February 2018. NYSOH will notify you once this has been done.

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

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).

- 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 February 7, 2018 disenrollment notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate your and your spouse's coverage for February 2018, and to notify you accordingly.

Your case is being sent back to NYSOH to reinstate your and your spouse's qualified health plan coverage for February 2018. NYSOH will notify you once this has been done.

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).