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

Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029360

[redacted]

Dear [redacted]

On May 3, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 11, 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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DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029360

[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 31, 2018?

Procedural History

On October 28, 2017, NYSOH issued a notice indicating your coverage for the 2018 coverage year was being automatically renewed. The notice stated that, based on income information received from state and federal data sources, you were eligible to receive up to $109.92 in monthly advance payments of the premium tax credit (APTC), effective January 1, 2018. The notice indicated you were being automatically reenrolled in your current qualified health plan (QHP), effective January 1, 2018. The notice further stated that to confirm or change the amount of APTC applied to your monthly premium, you must log into and update your tax credit after November 15, 2017.

On November 17, 2017, NYSOH issued an enrollment notice confirming your reenrollment in your Healthfirst Gold level QHP with $52.00 of APTC applied, effective January 1, 2018.

On December 27, 2017, NYSOH received two updated applications for financial assistance with health insurance submitted on your behalf.

On December 28, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $244.00 in APTC, for a limited time, effective

February 1, 2018. The notice directed you to submit proof of your income by March 27, 2018 to confirm your eligibility or you might lose your insurance or receive less help paying for your coverage.

Also on December 28, 2017, NYSOH issued an enrollment notice confirming your enrollment in your Healthfirst Gold level QHP with $52.00 of APTC applied, effective January 1, 2018.

On January 10, 2018, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf.

On January 11, 2018, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective January 1, 2018.

Also on January 11, 2018, NYSOH issued an enrollment notice, based on your January 10, 2018 plan selection, confirming your enrollment in a Medicaid Managed Care plan, effective February 1, 2018.

Additionally, on January 11, 2018, NYSOH issued a disenrollment notice stating your QHP enrollment would end, effective January 31, 2018.

On February 26, 2018, you contacted the NYSOH Account Review Unit and appealed the end date of your QHP enrollment insofar as that enrollment was not terminated effective January 1, 2018.

On May 3, 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 thereafter.

Findings of Fact

A review of the record supports the following findings of fact:

1) You testified you are only appealing the end date of your QHP enrollment. This appeal does not involve your child's coverage.

2) You were enrolled in a QHP with $52.00 of monthly APTC applied throughout 2017.

3) Your coverage was automatically renewed for 2018, based on income information from state and federal data sources, and you were found eligible for $109.92 of APTC, effective January 1, 2018.

4) You were automatically reenrolled in your Gold level QHP for 2018 with $52.00 of APTC, because you did not log into your account and change the amount of tax credits applied to your monthly premium.

5) Two updated applications were submitted on your behalf on December 27, 2017. The second application indicated that your annual expected household income for 2018 was $40,000.00 consisting solely of your self-employment income.

6) According to your account, NYSOH could not verify the income information in your application and found you conditionally eligible to receive up to $244.00 in APTC, effective February 1, 2018, with documentation of your income requested to confirm your eligibility.

7) Your account confirms that your gold level QHP enrollment was confirmed on December 27, 2017.

8) On January 10, 2017, an updated application was submitted on your behalf attesting to an annual expected income for 2018 of $13,772.04, based on the prior three months of your business income. You testified that a certified application counselor (CAC) assisted you with your application. You testified that you expect your annual income for 2018 to be higher than the amount listed in that application.

9) The same day, you uploaded documentation of your business income for the months of October through December 2017.

10) According to your account, NYSOH verified your income documentation and confirmed the income information in your application.

11) NYSOH systematically redetermined your eligibility the same day, January 10, 2018, and found you eligible for Medicaid, effective January 1, 2018.

12) According to your account, on January 10, 2018, your QHP enrollment was deleted online by your CAC. Your QHP enrollment ended January 31, 2018.

13) You appealed insofar as your QHP enrollment did not end January 1, 2018.

14) You testified that you were set up to have your monthly premium payments automatically deducted from your bank account by your QHP.

15) You testified that the health plan automatically deducted the January 2018 premium payment before you were determined eligible for Medicaid.

16) You testified that your health plan has also billed you for the difference between the amount of your automatic debit payment and the amount due for January 2018 as a result of a premium increase in 2018.

17) You testified that since your Medicaid eligibility became effective on January 1, 2018, your QHP enrollment should be retroactively terminated back to that date and you should be refunded the premium payment for January 2018.

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your QHP ended effective January 31, 2018.

On October 28, 2017, NYSOH issued renewal notice stating your coverage was automatically renewed for 2018, based on income information from state and federal data sources, and you were found eligible for $109.92 of APTC, effective January 1, 2018. The November 17, 2017 enrollment notice confirmed your QHP reenrollment, effective January 1, 2018.

Subsequently, your application was updated on December 27, 2017 and you were conditionally eligible to receive up to $244.00 in APTC, effective February 1, 2018, with documentation of your income requested to confirm your eligibility. Your account confirms that your 2018 gold level QHP enrollment was confirmed on December 27, 2017.

Your application was updated again on January 10, 2018 and documentation of your income was submitted the same day. NYSOH verified that documentation and determined you eligible for Medicaid, effective January 1, 2018. Your account confirms your CAC deleted your QHP enrollment online on January 10, 2018. That enrollment ended January 31, 2018.

You testified you are seeking retroactive disenrollment from your QHP effective January 1, 2018.

Pursuant to the above cited regulations, NYSOH must permit an enrollee to be retroactively disenrolled from their QHP if the enrollee demonstrates 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 for 2018, as confirmed in the November 11, 2018 and December 28, 2017 enrollment notices, 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 for 2018 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 QHP.

As discussed above, your application was updated on January 10, 2018 and, subsequently, NYSOH determined you eligible for Medicaid effective January 1, 2018. On January 11, 2018, NYSOH issued a disenrollment notice stating your QHP enrollment would end effective January 31, 2018.

You testified that you are seeking an earlier disenrollment date because you had Medicaid coverage in January 2018 when you were still enrolled in your QHP.

Pursuant to the regulations, 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 January 1, 2018 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. Therefore, your plan was properly terminated at the end of the calendar month in which you became eligible for Medicaid.

Accordingly, the January 11, 2018 enrollment confirmation notice stating your QHP enrollment would end, effective January 31, 2018, was correct and is AFFIRMED.

Decision

The January 11, 2018 disenrollment notice is AFFIRMED.

Effective Date of this Decision: May 10, 2018

How this Decision Affects Your Eligibility

This decision does not change your disenrollment date. Your enrollment in your QHP ended January 31, 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 January 11, 2018 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your QHP ended January 31, 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।

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).

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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