



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

## Notice of Decision

Decision Date: October 4, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000008298

[REDACTED]

Dear [REDACTED]

On September 27, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's December 10, 2015 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).

This page intentionally left blank.



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

## Decision

Decision Date: October 4, 2016

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000008298



## Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health (NYSOH) properly determine your enrollment in your qualified health plan ended effective December 31, 2015?

## Procedural History

On January 31, 2015, an eligibility determination notice was issued finding you eligible to receive advance premium tax credits up to \$275.00 per month, as well as cost-sharing reductions effective March 1, 2015.

That same day NYSOH issued a notice confirming your enrollment in a silver level qualified health plan. The notice further stated that if you paid your first month's premium, your coverage could start as early as March 1, 2015.

On December 10, 2015, the NYSOH issued an eligibility redetermination notice stating that you were eligible for Medicaid, effective December 1, 2015.

That same day, a disenrollment notice was issued stating you had requested to end your insurance coverage and that you would no longer have coverage with your qualified health plan effective December 31, 2015.

On December 25, 2015, an enrollment confirmation notice was issued confirming your enrollment in a Medicaid Managed Care plan effective February 1, 2016.

On March 24, 2016, you spoke to NYSOH's Account Review Unit and appealed the December 10, 2015 disenrollment notice insofar as it terminated your

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).

coverage under your qualified health plan on December 31, 2015 and not on November 30, 2015.

On September 27, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of proceeding.

## **Findings of Fact**

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

- 1) The record reflects that you were enrolled in a qualified health plan through NYSOH and that your coverage was effective as of March 1, 2015.
- 2) You testified that you paid premiums to your health plan for the months you had coverage. You testified that you did not pay your premium for the last month you had coverage of December, 2015.
- 3) You testified that you updated your application for renewal on December 9, 2015, and you were found eligible for Medicaid.
- 4) The record supports you were also found eligible for retro-Medicaid for the month of October, 2015.
- 5) You testified you requested that your insurance coverage through your qualified health plan be terminated on December 17, 2015. You testified this was because you had received a request for a premium payment from your health plan.
- 6) You testified you are concerned about being sent to collections for not paying a premium payment for the month of December 2015.
- 7) You testified you did not use your insurance through your qualified health plan during the month of December 2015 for which your health plan is seeking reimbursement.

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

## **Applicable Law and Regulations**

NY State of Health (NYSOH) must permit an enrollee to terminate his or her coverage with a qualified health plan, including when an enrollee obtains

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).

minimum essential coverage, with appropriate notice to the NYSOH or qualified health plan (45 CFR § 155.430(b)(1), (d)).

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)).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that the coverage provided by your qualified health plan ended on December 31, 2015.

On December 9, 2015, you contacted NYSOH to renew your eligibility. That day, you were found eligible for Medicaid effective December 1, 2015. As a result your enrollment in your qualified health be terminated. You testified that you may have made the request later on December 17, 2015, to end your qualified health plan coverage when you received a premium bill for that month.

Enrollees must be allowed to terminate their coverage with a qualified health plan if they provide appropriate notice to NYSOH or to their health plan.

If the 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 on December 9, 2015 under the regulations 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 in a qualified health plan and as such your plan was terminated at the end of the calendar month in which you became eligible for Medicaid.

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).

Although it is unclear from the record and information provided to NYSOH whether your health plan is still seeking reimbursement for premium payments for the month of December, 2015. Should you not pay that premium, you will not receive coverage for that month under the plan requirements.

Therefore, NYSOH properly determined that your plan terminated as of December 31, 2015, and NYSOH's December 10, 2015, disenrollment notice is AFFIRMED.

## **Decision**

The December 10, 2015 disenrollment notice is AFFIRMED.

**Effective Date of this Decision:** October 4, 2016

## **How this Decision Affects Your Eligibility**

Your coverage through your qualified health plan ended effective December 30, 2015.

## **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 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).

## **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 10, 2015, disenrollment notice is AFFIRMED.

Your coverage through your qualified health plan ended effective December 30, 2015.

## **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.

**A Copy of this Decision Has Been Provided To:**

