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

Notice of Decision

Decision Date: May 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013574

[redacted]

Dear [redacted],

On March 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 28, 2016 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: May 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013574

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly terminate your coverage through your Catastrophic Health Plan, effective October 31, 2016?

Procedural History

On October 29, 2015, NYSOH issued a notice stating, based on federal and state data sources, you still qualified to buy a health plan at full cost through NYSOH, effective January 1, 2016. The notice indicated you were being automatically reenrolled into your current Catastrophic Health Plan and dental plan for the 2016 coverage year, with coverage effective January 1, 2016.

On November 25, 2015, NYSOH issued an enrollment notice confirming your enrollment in a Catastrophic Health Plan and dental plan, effective January 1, 2016.

On October 20, 2016, NYSOH issued a notice stating it was time to renew your health insurance for the upcoming coverage year, beginning January 1, 2017. That notice stated you must select a different health plan, between November 16, 2016 and December 15, 2016, to continue your coverage for the upcoming year. The notice indicated you could not keep your current health plan, because it was only for people 29 years old and younger. The notice also directed you to select another dental plan for the upcoming year, because your current plan would be discontinued.

On October 28, 2016, NYSOH issued a disenrollment notice stating the coverage through your Catastrophic Health Plan would end effective October 31, 2016, because you were no longer eligible to remain enrolled in the plan. The notice directed you to pick a new plan right away to ensure there was no gap in your health coverage.

On November 23, 2016, NYSOH issued a notice stating your coverage through your dental plan would end effective December 31, 2016.

On November 28, 2016, you spoke to NYSOH's Account Review Unit and appealed the October 28, 2016 disenrollment notice insofar as it terminated coverage through your Catastrophic Health Plan on October 31, 2016.

On March 10, 2017, 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 the hearing.

Findings of Fact

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

1) You testified, and your account confirms, your date of birth [redacted].

2) You were enrolled in a Catastrophic Health Plan for the 2016 coverage year with coverage effective January 1, 2016.

3) You were [redacted] on January 1, 2016.

4) You turned [redacted] on [redacted].

5) NYSOH issued a renewal notice dated October 20, 2016. This notice indicated you had to select a new health plan for the 2017 coverage year because your current plan was only for people under the age of 30. This notice indicated you had until December 15, 2016 to select a new plan for the 2017 coverage year.

6) No notice of eligibility determination was issued by NYSOH regarding any change in eligibility for a catastrophic plan.

7) NYSOH issued a disenrollment notice on October 28, 2016 indicating your Catastrophic Health Plan would end on October 31, 2016, because you were no longer eligible to remain enrolled in the plan.

8) You testified you received the disenrollment notice but it was not in time to select a new plan for November 2016.

9) You testified you received the disenrollment notice after you had already paid the premium to your health plan for November 2016.

10) You testified you were without health coverage in November and December 2016, despite paying the November 2016 premium payment.

11) You requested an appeal on November 28, 2016, objecting to the cancellation of your coverage.

12) You testified you are also seeking a refund from your health plan for premiums pay for the month of November 2016.

13) You testified you have obtained health coverage outside NYSOH for the 2017 coverage year.

14) Your dental plan was terminated, effective December 31, 2016. You testified you are not seeking reinstatement of your dental plan.

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

Applicable Law and Regulations

Eligibility for Enrollment in Catastrophic Health Plans

An individual is eligible for enrollment in a Catastrophic Health Plan for any plan year if he has not attained the age of 30 before the beginning of the plan year (42 USC § 18022(e)(2), 45 CFR § 155.305(h)(1)).

Notice of Changes in Eligibility

NYSOH must provide timely written notice to an applicant of any eligibility determination (45 CFR § 155.310(g)).

Enrollment in a Qualified Health Plan

The effective date of coverage by a qualified health plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i)). For selections received by NYSOH from the sixteenth to the last day of any month,

NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Appealable Issues

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Legal Analysis

The issue under review is whether NYSOH properly terminated your coverage through your catastrophic health plan, effective October 31, 2016.

You were enrolled in a catastrophic health plan for the 2016 coverage year with coverage effective January 1, 2016. You were [redacted] at the time of enrollment. You testified, and your account confirms, you turned [redacted] old on [redacted]. NYSOH terminated your coverage through this plan, effective October 31, 2016.

Although the October 28, 2016 disenrollment notice issued by NYSOH does not provide a specific reason for the disenrollment, nor was there an eligibility determination notice issued regarding this disenrollment, a previous notice issued on October 20, 2016 indicated you were not eligible to remain in your current plan for the 2017 coverage year because you were over the age of 30. Accordingly, based on these notices, it is assumed NYSOH terminated your coverage through your Catastrophic Health Plan as of October 31, 2016, because you were over the age of 30.

Pursuant to the above cited regulations, individuals who have not attained the age of 30 before the beginning of the plan year are eligible for enrollment in a Catastrophic Health Plan. There is no legal authority to disenroll an individual form a Catastrophic plan mid-plan year because of that individual reaching 30 years of age.

As discussed above, you enrolled in your Catastrophic Health Plan, effective January 1, 2016. You were [redacted] at that time. Accordingly, the evidence establishes you had not attained the age of 30 before the beginning of the plan year and you were eligible to enroll in a Catastrophic Health Plan as of January 1, 2016. It is not relevant to your eligibility to remain in your Catastrophic Health

Plan that you turned 30 in 2017 as the sole requirement for enrollment is that the applicant be under the age of 30 before the beginning of the plan year. Therefore, your coverage should not have been terminated on these grounds.

Furthermore, the disenrollment notice was issued on October 28, 2016, three days before the proposed coverage end date of October 31, 2016. This was not adequate notice to allow you to select a new plan and prevent a gap in coverage.

The regulations provide that for coverage to be effective the first day of the following month, a plan must be selected from the first to the fifteenth of any month. As the notice that NYSOH was terminating your coverage came on October 28, 2016, after the fifteenth day of the month, any new plan selection would not have become effective until, at least, November 1, 2016, resulting in a gap in coverage.

NYSOH is required to provide applicants timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility. As the notice given in this case was not sufficient to provide a gap in coverage, it cannot be deemed timely or adequate.

Therefore, the October 28, 2016 disenrollment notice stating your coverage through your Catastrophic Health Plan was terminated, effective October 31, 2016, is not correct and must be RESCINDED.

It is noted that you testified you are seeking reimbursement of the November 2016 premium payment you made to the health plan prior to the termination of your coverage. However, pursuant to the above regulations, the Appeals Unit of NYSOH does not have the authority to review issues pertaining to payments or reimbursements of premium payments.

Your case is RETURNED to NYSOH to reinstate your coverage in your Catastrophic Health Plan for the months of November and December 2016.

Decision

The October 28, 2016 disenrollment notice is RESCINDED.

Your coverage through your Catastrophic Health Plan should not have ended until December 31, 2016.

Your case is being sent back to NYSOH to assist you in reinstating your Catastrophic Health Plan for the months of November and December 2016, if you so choose.

Effective Date of this Decision: May 01, 2017

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).

How this Decision Affects Your Eligibility

Your coverage through your Catastrophic Health Plan should not have ended until December 31, 2016.

Your case is being sent back to NYSOH to assist you in reinstating your Catastrophic Health Plan for the months of November and December 2016, if you so choose.

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.

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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 October 28, 2016 disenrollment notice is RESCINDED.

Your coverage through your Catastrophic Health Plan should not have ended until December 31, 2016.

Your case is being sent back to NYSOH to assist you in reinstating your Catastrophic Health Plan for the months of November and December 2016, if you so choose.

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 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)

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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