



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

Notice of Decision

Decision Date: May 11, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014779

[REDACTED]

Dear [REDACTED]

On May 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 1, 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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Decision

Decision Date: May 11, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014779



Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Did NY State of Health (NYSOH) properly determine that your child's qualified health plan (QHP) should terminate effective September 30, 2016?

Whether NYSOH's Appeals Unit can consider your request for reimbursement of your child's health insurance premium?

Procedural History

On November 23, 2015, NYSOH issued an eligibility determination notice stating, in relevant part, that your child was eligible to purchase a QHP at full cost effective January 1, 2016.

On November 25, 2015, NYSOH issued an enrollment notice confirming that your child was enrolled in a QHP with an enrollment start date of January 1, 2016.

On August 31, 2016, your NYSOH account was updated.

On September 1, 2016, NYSOH issued a disenrollment notice stating that your child's QHP would be terminated effective September 30, 2016.

On January 11, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as the date that your child's QHP was terminated.

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On May 2, 2017, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was 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 and testimony, your child was enrolled in QHP with an enrollment start date of January 1, 2016.
- 2) You testified that you contacted NYSOH in the beginning of August 2016 to cancel your child's QHP. However, you were informed by a representative that you must call at a later date to cancel the plan.
- 3) You testified that you were seeking to terminate your child's coverage because their employer-sponsored health insurance was effective September 1, 2016.
- 4) According to your NYSOH account, on August 31, 2016 you contacted NYSOH and terminated your child's health insurance coverage.
- 5) According to the Appeal Summary in the Evidence Packet ([REDACTED]), a complaint was submitted on August 31, 2016 ([REDACTED]) because a representative gave misinformation on when you should call to terminate your child's coverage.
- 6) According to the Appeal Summary in the Evidence Packet, NYSOH sent "data corrections" on August 31, 2016 ([REDACTED]) and November 28, 2016 ([REDACTED]) to have the coverage termination date changed from 09/30/2016 to 08/31/2016.
- 7) According to the Appeals Summary in the Evidence Packet, as of January 20, 2017 ([REDACTED]), the system already reflected a termination date of 8/31/2016.
- 8) You testified that you are seeking reimbursement of the portion of the September 2016 health insurance premium that was paid toward your child's coverage.

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

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).

NYSOH must permit an enrollee to terminate his or her coverage with a QHP with appropriate notice to NYSOH (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 QHP 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 QHP 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 QHP 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 QHP 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 QHP 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)).

Appealable Issues

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).

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 NYSOH 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 first issue under review is whether NYSOH properly terminated your child's QHP enrollment effective September 30, 2016.

On November 23, 2015, and November 25, 2015, NYSOH issued notices stating that your child was eligible to purchase a QHP at full cost, and that your child was enrolled in a QHP effective January 1, 2016.

An enrollee must be allowed to terminate their coverage in a QHP if they provide appropriate notice to NYSOH. Reasonable notice is at least fourteen days before the requested effective date of termination.

The available record reflects that you contacted NYSOH on August 10, 2016 to cancel your child's QHP, however, you were informed by a representative that you must call at a later date to cancel the plan. Subsequently, you contacted NYSOH on August 31, 2016, and cancelled your child's coverage with a termination date of September 30, 2016.

The record reflects that NYSOH submitted data corrections on August 31, 2016, and November 28, 2016 to change your child's termination date to August 31, 2016 (see [REDACTED]). Furthermore, your NYSOH account reflects that your child's coverage was terminated effective August 31, 2016 (see [REDACTED]).

Based on the credible evidence, you contacted NYSOH on August 10, 2016, to cancel your child's QHP. Therefore, the September 1, 2016, disenrollment notice is MODIFIED to state that your child's QHP would be terminated effective August 31, 2016.

The second issue under review is whether NYSOH's Appeals Unit can consider your appeal seeking reimbursement of health insurance premiums.

You testified that you are seeking reimbursement for the portion of the September 2016 health insurance premium that was paid toward your child's coverage.

NYSOH Appeals Unit only has the authority to review issues related to the following: (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 to provide timely notice of an eligibility determination and (5) a denial of a special enrollment period.

The Appeals Unit does not have the authority to review whether an individual should be reimbursed for premiums paid to a health plan. We cannot reach the merits as to whether you are entitled to be reimbursed for that payment. Therefore, your request for reimbursement for amount paid to Healthfirst for your child's coverage for the month of September 2016 is **DISMISSED** as a non-appealable issue.

However, your case is **REFERRED** to NYSOH's Plan Management Unit to facilitate the possible reimbursement of the portion of the September 2016 premium that was paid toward your child's coverage.

Decision

The September 1, 2016, disenrollment notice is **MODIFIED** to state that your child's QHP would be terminated effective August 31, 2016.

Your request for reimbursement for amount paid to Healthfirst for your child's coverage for the month of September 2016 is **DISMISSED** as a non-appealable issue.

Your case is **REFERRED** to NYSOH's Plan Management Unit to facilitate the possible reimbursement of the portion of the September 2016 premium that was paid toward your child's coverage.

Effective Date of this Decision: May 11, 2017

How this Decision Affects Your Eligibility

Your child's QHP was terminated effective August 31, 2016.

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.

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).

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

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).

The September 1, 2016, disenrollment notice is MODIFIED to state that your child's QHP would be terminated effective August 31, 2016.

Your request for reimbursement for amount paid to Healthfirst for your child's coverage for the month of September 2016 is DISMISSED as a non-appealable issue.

Your case is REFERRED to NYSOH's Plan Management Unit to facilitate the possible reimbursement of the portion of the September 2016 premium that was paid toward your child's coverage.

Your child's QHP was terminated effective August 31, 2016.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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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