



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

## Notice of Decision

Decision Date: May 4, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015000

[REDACTED]

Dear [REDACTED],

On April 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 15, 2016 eligibility determination notice and December 31, 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 4, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015000

[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 a bronze-level Qualified Health Plan (QHP) ended effective January 31, 2017?

## Procedural History

On December 15, 2016, NYSOH issued an eligibility determination notice, based on the information contained in the December 14, 2016 application, stating that you were eligible to receive advance premium tax credit in an amount up to \$176.00 per month, effective January 1, 2017.

Also on December 15, 2016, NYSOH issued a plan enrollment notice, based on your December 14, 2016 plan selection, confirming your enrollment in a bronze-level QHP at a cost of \$248.52 per month, effective January 1, 2017.

On December 31, 2016, NYSOH issued a plan enrollment notice, based on your December 31, 2016 plan selection, confirming your enrollment in a Catastrophic Plan at a cost of \$164.14 per month, effective February 1, 2017.

Also on December 31, 2016, NYSOH issued a disenrollment notice indicating that coverage in your bronze-level QHP would end effective January 31, 2017.

On January 20, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of your enrollment as it related to the disenrollment date of

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your bronze-level QHP, requesting that disenrollment date be made effective January 1, 2017.

On April 19, 2017, 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 hearing.

## **Findings of Fact**

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

- 1) According to your NYSOH account and your testimony, on December 30, 2016 the following events occurred: (a) You contacted NYSOH to disenroll from your bronze-level QHP through NYSOH; (b) You updated your account and you were found eligible for a Catastrophic plan, effective February 1, 2017; and (c) You enrolled in a Catastrophic plan that same day.
- 2) You testified that you paid a premium to your QHP for the month of January 2017 and you are seeking retroactive disenrollment from your bronze-level QHP, effective January 1, 2017. You further testified that you believe you should be refunded the premium you paid for that month.
- 3) You testified that you were told by a NYSOH representative, on December 30, 2016, that you would not have coverage in January 2017. As a result, you put off going to the doctor's that month.

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 QHP coverage, with appropriate notice to the NYSOH or QHP (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);

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- 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)).

## **Legal Analysis**

The issue under review is whether NYSOH properly disenrolled you from your bronze-level QHP, effective January 31, 2017.

On December 31, 2016, NYSOH issued a disenrollment notice indicating you would be disenrolled from your bronze-level QHP effective January 31, 2017.

You testified that you are seeking retroactive disenrollment from your bronze-level QHP effective January 1, 2017.

NYSOH must permit an enrollee to be retroactively disenroll from their QHP if the enrollee demonstrates that 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 as confirmed in the December 15, 2016 plan enrollment notice 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 as confirmed in the December 15, 2016 plan enrollment notice was without your knowledge or consent.

Therefore, there is no basis in this regard to find that NYSOH must permit you to retroactively terminate or cancel your enrollment in a QHP to January 1, 2017.

Next, enrollees must be allowed to terminate their coverage with a QHP at the date they specify if they provide reasonable notice to NYSOH or to their health plan. Reasonable notice is defined as at least 14 days prior to the requested termination date.

To be able to be disenrolled from your bronze-level QHP as of January 1, 2017, you had to provide notice no later than December 17, 2016 to meet the reasonable notice standard. The record reflects that on December 30, 2016, you contacted NYSOH and requested to be disenrolled from your bronze-level QHP as you no longer wanted to remain enrolled.

Therefore, and in keeping with the 14-day reasonable notice requirement, the earliest you could be disenrolled was the last day of the next month following December 30, 2016, which was January 31, 2017. The record reflects that NYSOH properly terminated your insurance coverage with your bronze-level QHP effective as of that date.

Since you do not qualify to be retroactively disenrolled from your bronze-level coverage and you did not provide reasonable notice to NYSOH to be disenrolled as of January 1, 2017, NYSOH properly determined that the earliest your disenrollment from your bronze-level QHP could take effect was January 31, 2017.

Therefore, the December 31, 2016, disenrollment notice is **AFFIRMED**.

## **Decision**

The December 31, 2016 disenrollment notice is AFFIRMED.

**Effective Date of this Decision:** May 4, 2017

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

This decision does not change your disenrollment date. Your enrollment in your bronze-level QHP began January 1, 2017 and ended as of January 31, 2017.

## **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 QHPs, s, 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 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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

## **Summary**

The December 31, 2016 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your bronze-level QHP began January 1, 2017 and ended as of January 31, 2017.

## **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।

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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 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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