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

Notice of Decision

Decision Date: May 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015737

[redacted]

Dear [redacted],

On May 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 6, 2017 enrollment 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
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Decision

Decision Date: May 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015737

[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 you and your child were enrolled in your qualified health plan from January 1, 2017 through January 31, 2017?

Procedural History

On October 22, 2016, NY State of Health (NYSOH) issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that you and your child were qualified to buy a health plan at full cost through NYSOH, effective January 1, 2017. The notice further advised you that you were being re-enrolled in your qualified health plan with a plan start date of January 1, 2017. The notice also stated that if you wanted to make any changes, these would need to be made between November 16, 2016 and December 15, 2016, for your new plan to be effective January 1, 2017.

On January 1, 2017, NYSOH issued a disenrollment notice stating that your and your child's enrollment in your qualified health plan would end on December 31, 2016.

On January 5, 2017, you updated your household's application for financial assistance with health insurance.

Also on January 5, 2017, NYSOH created incident [redacted] based on your request to have your and your child's enrollment in your qualified health plan effective as of January 1, 2017.

On January 6, 2017, NYSOH issued an eligibility determination notice stating that you and your child were eligible to purchase a qualified health plan at full cost effective February 1, 2017.

Also on January 6, 2017, NYSOH issued an enrollment notice confirming your and your child's enrollment in a qualified health plan effective February 1, 2017.

On January 23, 2017, NYSOH made a determination on incident #[redacted] and granted your request to back date your and your child's enrollment to January 1, 2017.

On February 10, 2017, you contacted the NYSOH Account Review Unit and appealed insofar as you no longer wanted coverage for January 1, 2017 through January 31, 2017, requesting that your and your child's enrollment be effective as of February 1, 2017.

On May 18, 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 proceeding.

Findings of Fact

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

1) You testified, and the record reflects, that you receive all your notices from NYSOH by electronic mail.

2) You testified that you received an e-mail alert directing you to the October 22, 2016 renewal notice. You further testified that based on the renewal notice, you believed that you and your child's coverage would start on January 1, 2017 and that there was nothing further you needed to do.

3) Your NYSOH account reflects that when you completed your application for financial assistance with health insurance on December 7, 2015, you selected to have your household's coverage automatically renewed for the next five years.

4) You testified that in December 2016 you received a bill from your qualified health plan for January 2017, and that you made your premium payment by the due date.

5) You testified that on January 1, 2017 or January 2, 2017 you received an e-mail alert directing you to a notice advising you that neither you nor your child was in enrolled in your plan for 2017.

6) You testified that shortly thereafter, you contacted your plan and updated your application. You were advised that you and your child's enrollment in your qualified health plan would begin on February 1, 2017, and you were directed to contact NYSOH regarding coverage for January 2017.

7) The record reflects that on January 5, 2017 you contacted NYSOH and incident # [redacted] was created. You testified that at that time you requested that NYSOH allow you and your child to be enrolled in your plan as of January 1, 2017. You further testified that NYSOH took your information, and advised you that they would review your request.

8) The record reflects that on January 23, 2017, NYSOH made a determination on you and your child's enrollment start date, and enrolled you and your child into your plan as of January 1, 2017. (See incident # [redacted])

9) You went on to testify that neither you nor your child went to the doctor or filled any prescriptions in January 2017 as you assumed you had no coverage for that month.

10) You testified that you received a letter from NYSOH dated January 24, 2017 advising you that your and your child's enrollment had been backdated to begin as of January 1, 2017. However, you no longer wanted coverage for January 2017 when you received that letter.

11) The record reflects that on February 10, 2017, you contacted NYSOH and advised that you no longer wanted your and your child's coverage to begin on January 1, 2017, as by the time you learned that you and your child had coverage for January 2017, it was too late for you to use your coverage in January 2017.

12) You testified that you are seeking for yourself and your child to be disenrolled from your qualified health plan for the month of January 1, 2017 only.

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)).

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 you and your child were enrolled in your qualified health plan from January 1, 2017 through January 31, 2017.

On January 6, 2017, NYSOH issued an eligibility determination notice stating that you and your child were eligible to purchase a qualified health plan at full cost effective February 1, 2017. You subsequently enrolled yourself and your child into a qualified health plan, with a plan enrollment start date of February 1, 2017.

On January 5, 2017, you requested that NYSOH enroll you and your child in your qualified health plan as of January 1, 2017. NYSOH did grant this request and on January 23, 2017, NYSOH enrolled you and your son into your qualified health plan as of January 1, 2017.

You testified that you learned of this resolution in a letter dated January 24, 2017. However, by the time this request was processed, you no longer wanted to have coverage as of January 1, 2017.

The record reflects that on February 10, 2017 you contacted NYSOH and requested that you and your child be disenrolled from your qualified health plan for the month of January 2017.

NYSOH must permit an enrollee to be retroactively disenrolled from their qualified health plan 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 qualified health plan without their knowledge or consent by a third party.

The record reflects that NYSOH erred when it failed to automatically renew you and your child into your qualified health plan for January 1, 2017. Although NYSOH attempted to rectify this error, when you and your child's enrollment into your qualified health plan for January 1, 2017 through January 31, 2017 was processed, you no longer wished to be enrolled in your qualified health plan for January 2017. Additionally, you contacted NYSOH within 60 days of discovering the mistaken enrollment. Therefore, your and your child's enrollment in your

qualified health plan from January 1, 2017 through January 31, 2017 was the result of an error by an agent of NYSOH.

Therefore, NYSOH must permit you to retroactively terminate or cancel you and your child's enrollment in your qualified health plan.

As the January 6, 2017 enrollment confirmation notice began you and your child's enrollment in your qualified health plan as of February 1, 2017, it is correct and is AFFIRMED.

Decision

The January 6, 2017 enrollment confirmation notice is AFFIRMED.

Your case is RETURNED to NYSOH to disenroll you and your child from your qualified health plan from January 1, 2017 through January 31, 2017.

Effective Date of this Decision: May 23, 2017

How this Decision Affects Your Eligibility

Your case is being sent back to disenroll you and your child from your qualified health plan for the month of January 2017 only.

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 6, 2017 enrollment confirmation notice is AFFIRMED.

Your case is RETURNED to NYSOH to disenroll you and your child from your qualified health plan from January 1, 2017 through 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:

[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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