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

Notice of Decision

Decision Date: June 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015954

[redacted]

Dear [redacted],

On May 31, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 17, 2017 and February 16, 2017 disenrollment notices.

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: June 29, 2017

NY State of Health Account ID: [redacted]
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Issues

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

> Did NY State of Health (NYSOH) properly determine your children's enrollment in a Child Health Plus plan ended effective January 1, 2017?
>
> Did NYSOH properly determine that your and your spouse's enrollment in a qualified health plan ended effective January 1, 2017?

Procedural History

On December 6, 2015, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to receive up to $468.00 in advance payments of the premium tax credit (APTC) as well as cost-sharing reductions if you enrolled in a silver level qualified health plan. Your children were eligible for Child Health Plus with a monthly premium of $9.00. Your household's eligibility was effective as of January 1, 2016.

Also on December 6, 2015, NYSOH issued an enrollment confirmation notice stating that you and your spouse were enrolled in a bronze level qualified health plan and your children were enrolled in a Child Health Plus plan, effective January 1, 2016.

On October 21, 2016, NYSOH issued a renewal notice stating your household was re-enrolled in your current health plans, and no action was required. Your children were determined eligible for Child Health Plus, and you and your spouse

were determined eligible to receive up to $512.55 per month in APTC, effective January 1, 2017.

On November 18, 2016, NYSOH issued an enrollment notice confirming your and your spouse's enrollment in a qualified health plan and your children's enrollment in a Child Health Plus plan, effective January 1, 2017.

On January 17, 2017, NYSOH issued a disenrollment notice indicating your children's coverage in a Child Health Plus plan would end effective January 1, 2017.

On February 16, 2017, NYSOH issued a disenrollment notice indicating your and your spouse's coverage in your qualified health plan would end effective January 1, 2017.

On February 17, 2017, you contacted the NYSOH Account Review Unit and appealed the date you and your spouse were disenrolled from your qualified health plan and the date your children were disenrolled from their Child Health Plus plan, requesting the disenrollment be made effective October 1, 2016.

On May 31, 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 that you became eligible for insurance through your employer as of September 12, 2016.

2) You testified that on September 12, 2016, you contacted your health plan to disenroll yourself and your spouse from your qualified health plan and your children from their Child Health Plus plan. You stated that you believed your coverage to be terminated at this point.

3) You testified that your health plan did not advise you that you should contact NYSOH to disenroll your household from coverage, and you were not aware that you should do so.

4) You testified that you first contacted NYSOH to request disenrollment from your and your spouse's qualified health plan and your children's Child Health Plus plan in January 2017.

5) You testified that you have not paid premiums to your qualified health plan since September 2016.

6) You testified that you have not been billed for any plan premiums since September 2016.

7) You testified that your household has not used insurance through NYSOH since September 12, 2016.

8) You testified that you are seeking retroactive disenrollment from your and your spouse's qualified health plan and from your children's Child Health Plus plans effective October 1, 2016.

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

Applicable Law and Regulations

Child Health Plus

The "period of eligibility" for Child Health Plus is "that period commencing on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment on an annual basis based on all required information and documentation and ending on the last day of the twelfth month following such date," unless the CHP premiums are not timely paid or the child no longer resides in New York State, gains access to or obtains other health insurance coverage, or becomes eligible for Medicaid (NY Public Health Law § 2510(6)).

Child Health Plus Disenrollment Date

The State plan must include a description of the state's policies governing enrollment and disenrollment (*see* 42 CFR § 457.305(b)). Eligibility rules are set out in NY Public Health Law § 2511(2), as well as in the NYSDOH 2008-2012 Contract and Plan Manual.

If the enrollee requests a disenrollment, the request is effective the first day of the month following the receipt of the enrollee's request or effective on a future date if requested by the enrollee (NYSDOH 2008-2012 Model Contract (Appendix C Section 12.2)).

If the enrollee gains access to a state health benefits plan or becomes in enrolled in other health insurance, the enrollee shall be disenrolled effective the first day of the month following the date that the enrollee provides information regarding other insurance (NYSDOH 2008-2012 Model Contract (Appendix C Section 12.3)).

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 first issue under review is whether NYSOH properly determined that your children's enrollment in a Child Health Plus plan ended effective January 1, 2017.

Your children were enrolled in a Child Health Plus plan effective January 1, 2016.

On October 21, 2016, NYSOH issued a renewal notice stating your household was re-enrolled in your current health plans, and no action was required. Your children were determined eligible for Child Health Plus, effective January 1, 2017. Your children were subsequently enrolled into a Child Health Plus plan.

You testified, and the record confirms, that you contacted NYSOH and requested that your children be disenrolled from their Child Health Plus plans in January 2017. Based on this request, on January 17, 2017, NYSOH issued a disenrollment notice indicating that your children's coverage in a Child Health Plus plan would end effective January 1, 2017.

Enrollees may request disenrollment from their Child Health Plus plan at any time. If the enrollee requests a disenrollment, the request is effective the first day of the month following the receipt of the enrollee's request or effective on a future date if requested by the enrollee. If the enrollee gains access to a state health benefits plan or becomes in enrolled in other health insurance, the enrollee shall be disenrolled effective the first day of the month following the date that the enrollee provides information regarding other insurance.

You testified that you contacted your health plan on the day your employer sponsored coverage became effective, or September 12, 2016, to request cancellation of your children's Child Health Plus coverage. You were not notified that you should contact NYSOH. You testified that you did not notify NYSOH until January 2017 that your children were enrolled in other health insurance, and there is no documentation in your account as evidence of contact with the health plan. Additionally, there is no indication in your account that your children had health insurance outside of NYSOH until February 2017. Because you did not notify NYSOH until January 2017, NYSOH properly determined that your children's coverage would end effective January 1, 2017.

Therefore, the January 17, 2017 disenrollment notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined that your and your spouse's enrollment in a qualified health plan ended effective January 1, 2017.

You testified that you are seeking retroactive disenrollment from your and your spouse's qualified health plan effective October 1, 2016.

On October 21, 2016, NYSOH issued a renewal notice stating your household was re-enrolled in your current health plans, and no action was required. You and your spouse were determined eligible to receive up to $512.55 per month in APTC effective January 1, 2017. You and your spouse subsequently were enrolled into a qualified health plan.

You testified that in January 2017 you contacted NYSOH and requested to be disenrolled from your qualified health plan as you no longer wanted to remain enrolled. As a result, NYSOH terminated your and your spouse's enrollment effective January 1, 2017.

On February 16, 2017, NYSOH issued a disenrollment notice indicating that your and your spouse's coverage in your qualified health plan would end effective January 1, 2017.

You testified that you contacted your health plan on the day your employer sponsored coverage became effective, or September 12, 2016, to request cancellation of coverage for your household. You testified that the health plan did not advise you to contact NYSOH, and that you were under the impression that your coverage had been discontinued at that point.

Enrollees must be allowed to terminate their coverage with a qualified health plan 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.

Although you testified that you contacted your health plan on September 12, 2016, you did not contact NYSOH until January, and there is no documentation in your NYSOH account as evidence of contact with the health plan. Furthermore, there is no indication in your account that you had health insurance outside of the Marketplace until February 2017. Therefore, NYSOH properly determined that your and your spouse's disenrollment was effective January 1, 2017.

Therefore, the February 16, 2017 disenrollment notice is AFFIRMED.

Decision

The January 17, 2017 disenrollment notice is AFFIRMED.

The February 16, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: June 29, 2017

How this Decision Affects Your Eligibility

This decision does not change your disenrollment date. Your and your spouse's enrollment in your qualified health plan and your children's enrollment in a Child Health Plus plan properly ended effective January 1, 2017.

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 17, 2017 disenrollment notice is AFFIRMED.

The February 16, 2017 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your and your spouse's enrollment in your qualified health plan and your children's enrollment in a Child Health Plus plan properly ended effective January 1, 2017.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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.

□□□□□ (Bengali)

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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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.

(Urdu)اردو

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.

(Yiddish) אידיש

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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.

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).