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

Notice of Decision

Decision Date: July 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017181

[redacted]

Dear [redacted]

On June 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 24, 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: July 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017181

[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 qualified health plan ended effective December 1, 2016?

Procedural History

NYSOH records dated December 22, 2015 reflect that you were determined eligible for a full cost qualified health plan, effective January 1, 2016.

On December 24, 2015, NYSOH issued a letter confirming your enrollment in a full cost qualified health plan with a monthly premium responsibility of $330.49, effective January 1, 2016.

On October 19, 2016, NYSOH issued a notice advising you that it was time to renew your coverage for the upcoming year, but that you would need to select a new plan between November 16, 2016 and December 15, 2016 to continue coverage.

On October 24, 2016, you updated your account several times, before period described in the October 19, 2016 notice.

On November 16, 2016, NYSOH issued a second renewal notice, stating that you still qualified for a full cost qualified health plan, effective January 1, 2017. The notice stated that you could not remain in your current plan and that you

needed to select a different health plan between November 16, 2016 and December 15, 2016 to continue your coverage.

On November 17, 2016, you contacted NYSOH to update your account and to select a qualified health plan.

On November 18, 2016, issued an eligibility determination notice, stating that you were eligible to enroll in a full cost QHP.

Also on November 18, 2016, NYSOH issued a notice confirming your enrollment in a new plan, effective January 1, 2017.

NYSOH records reflect that on November 17, 2016, your coverage in your qualified health plan was terminated effective November 30, 2016; however, no notice was issued formalizing any eligibility determination that would warrant such an action.

On November 24, 2016, NYSOH issued a disenrollment notice stating that your coverage in your former qualified health plan was ending December 31, 2016. The notice stated that the reason was “because you told us you moved to another county.”

On March 23, 2017, you spoke to NYSOH’s Account Review Unit and appealed the eligibility determination insofar as your eligibility and enrollment in a qualified health plan ended on December 1, 2016.

On June 7, 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 supports the following findings of fact:

1) You testified, and the record reflects, that you were enrolled in a full cost qualified health plan, Affinity, with a monthly premium of $330.49 and a start date of January 1, 2016.

2) You testified that you received a renewal notice from NYSOH requesting that you update your account by December 15, 2016.

3) You testified that on November 17, 2016, you contacted NYSOH by telephone and that a NYSOH representative asked you to verify your personal information including your address. You testified that you verified your address as [redacted]

4) NYSOH records reflect that on November 17, 2016, your coverage in your qualified health plan was terminated effective November 30, 2016; however, this is not reflected in any notice sent to you.

5) You testified that you enrolled in a qualified health plan, Fidelis, effective January 1, 2017.

6) You testified that you received medical bills in late February 2017 and March 2017 for medical care which you received in December 2016. You contacted NYSOH in March 2017 and was advised by a NYSOH representative that due to a system defect you were disenrolled from your qualified health plan effective November 30, 2016.

7) On March 23, 2017, NYSOH filed Incident [redacted] which stated "…On 11/17/2016 the appellant contacted the market place to update the account and was determined eligible for full cost QHP. Enrollment was submitted with [redacted] effective 01/01/2017. Due to defect error and system not recognizing address an auto disenrollment was submitted with [redacted] effective 11/30/2016 due to defect on account, causing appellant to have no coverage for the month of December 2016."

8) You testified that you have lived at [redacted] for the past 12 years and currently reside at that address.

9) You testified that you did not advise NYSOH that you had a change in address.

10) You testified that you incurred $2,400.00 in medical bills during the month of December 2016.

11) You testified that you did not receive any notice from NYSOH that your coverage in your qualified health plan was ending December 1, 2016.

12) You testified that you paid your premium of $330.49 to your carrier for the month of December 2016 and that it has not been reimbursed.

13) You testified that you are seeking to have your enrollment reinstated in your Affinity qualified health plan for the month of December 2016.

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

Applicable Law and Regulations

Redetermination During a Benefit Year

When a redetermination is issued as a result of a change in an applicant's information, NYSOH must generally make that redetermination effective on the first day of the month following the date NYSOH is notified of the change (45 CFR § 155.330 (f)(1)(ii)). However, NYSOH may determine that its policy will be that any change made after the 15th of any month will not be effective until the first of the second following month (45 CFR § 155.330(f)(2)).

When an eligibility redetermination results in a change in the amount of advance payments of the premium tax credit (APTC) for the benefit year, NYSOH must recalculate the amount of APTC in such a manner as to account for any advance payments already made on behalf of the tax filer, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for that benefit year (45 CFR § 155.330(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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in a qualified health plan ended effective December 1, 2016.

The record shows that on December 24, 2015, NYSOH issued an enrollment confirmation notice stating that your enrollment in your full cost qualified health plan was effective January 1, 2016.

You testified that after receiving your renewal notice, you contacted NYSOH on November 17, 2016 to update your account and select a new plan for 2017. You testified that on that date a NYSOH representative asked you to verify your personal information including your address. You testified that you verified your address as [redacted].

You testified that you did not receive any notice from NYSOH advising that your coverage in your qualified health plan was ending effective December 1, 2017. You testified that the disenrollment notice you received from NYSOH indicated that your coverage was ending December 31, 2016. However, NYSOH records reflect that on November 17, 2016, your coverage in your qualified health plan was terminated effective November 30, 2016.

This loss of coverage effective November 30, 2016 is supported by NYSOH records which stated "…On 11/17/2016 the appellant contacted the market place to update the account and was determined eligible for full cost QHP. Enrollment was submitted with [redacted] effective 01/01/2017. Due to defect error and system not recognizing address an auto disenrollment was submitted with [redacted] effective 11/30/2016 due to defect on account, causing appellant to have no coverage for the month of December 2016."

However, a review of the record reflects that you did not change your address or move counties. You testified, and the record reflects, that your address is [redacted] You testified that you have lived at [redacted] for the past 12 years and currently reside at that address.

The Appeals Unit finds that on November 17, 2016, a system defect led to NYSOH being unable to recognize your address, and NYSOH incorrectly submitted an auto disenrollment effective November 30, 2016. No notice was sent out to you. Both the baseless disenrollment and the lack of notice were improper.

Therefore, NYSOH having ended your coverage in your Affinity qualified health plan effective December 1, 2016 was incorrect and NYSOH's November 24, 2016 disenrollment notice is AFFIRMED, to confirm that your enrollment in your former plan did not end until December 31, 2016.

Decision

The November 24, 2016 disenrollment notice is AFFIRMED, to confirm that your enrollment in your former plan should not have ended until December 31, 2016.

Your case is being RETURNED to NYSOH to reinstate your coverage in your Affinity qualified health plan for the month of December 2016, if you so choose.

Effective Date of this Decision: July 26, 2017

How this Decision Affects Your Eligibility

Your enrollment in your qualified health plan was incorrectly terminated effective December 1, 2016; at your option you may reinstate your coverage for that month. You may owe an additional premium.

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 November 24, 2016 disenrollment notice is AFFIRMED, to confirm that your enrollment in your former plan should not have ended until December 31, 2016.

Your case is being RETURNED to NYSOH to reinstate your coverage in your Affinity qualified health plan for the month of December 2016, if you so choose.

Your enrollment in your qualified health plan was incorrectly terminated effective December 1, 2016; at your option you may reinstate your coverage for that month. You may owe an additional premium.

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)

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).

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।

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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