



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

## Notice of Decision

Decision Date: October 17, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018408

[REDACTED]

Dear [REDACTED],

On September 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 29, 2017 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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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: October 17, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018408



## 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 spouse's enrollment in your qualified health plan ended effective April 30, 2017?

## Procedural History

On March 9, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to receive up to \$618.00 in advance payment of the premium tax credit for a limited time, effective April 1, 2017.

Also on March 9, 2017, NYSOH issued an enrollment notice confirming your and your spouse's enrollment in a qualified health plan effective January 1, 2017.

On March 28, 2017, income information in your NYSOH account was updated.

On March 29, 2017, NYSOH issued a notice stating that the income information in your application did not match state and federal data sources. You were directed to produce income documentation by April 12, 2017, and your spouse was directed to produce citizenship documentation by June 26, 2017.

Also on March 29, 2017, NYSOH issued a disenrollment notice stating that coverage in your and your spouse's qualified health plan would end effective April 30, 2017.

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On April 5, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, and your spouse was conditionally eligible for Medicaid, effective April 1, 2017.

Also on April 5, 2017, NYSOH issued a notice stating that you were eligible for retroactive Medicaid coverage for the months of December 2016 through February 2017.

On April 26, 2017, you contacted the NYSOH Account Review Unit and appealed the date you and your spouse were disenrolled from your qualified health plan, insofar as you were seeking the return of your premium payments from January 2017 through April 2017.

On September 15, 2017, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit, with the assistance of [REDACTED] interpreter # [REDACTED]. 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) The record reflects that you and your spouse were enrolled in a qualified health plan through NYSOH and that your coverage was effective as of January 1, 2017.
- 2) You testified that you paid premiums to your health plan for the months you had coverage.
- 3) The record indicates that you updated your application on March 28, 2017, and you were found eligible for Medicaid on April 4, 2017
- 4) You testified that you are seeking an earlier disenrollment date because you now have Medicaid coverage for January 2017, February 2017, and April 2017, when you were still enrolled in your qualified health plan.
- 5) You testified you used your insurance through your qualified health plan once a month from January 2017 through April 2017.

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

## **Applicable Law and Regulations**

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## 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)).

If an enrollee is newly eligible for Medicaid, the last day of coverage for the qualified health plan is the day before the Medicaid coverage begins (45 CFR § 155.430(d)(2)(iv)).

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)).

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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 spouse's enrollment in your qualified health plan ended effective April 30, 2017.

On March 9, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to receive up to \$618.00 in advance payment of the premium tax credit for a limited time, effective April 1, 2017. You and your spouse were enrolled into a qualified health plan.

You testified that you are seeking retroactive disenrollment from your qualified health plan effective January 1, 2017. You testified that you are seeking to have the return of premiums paid from January 2017 through April 2017.

NYSOH must permit an enrollee to be retroactively disenroll 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.

There is no indication in the record that your enrollment in a qualified health plan as confirmed in the March 9, 2017 enrollment notice was unintentional, inadvertent, or erroneous, nor was your enrollment in a qualified health plan 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 qualified health plan as confirmed in the March 9, 2017 enrollment notice was without your knowledge or consent.

Therefore, there is no basis to find that NYSOH must permit you to retroactively terminate or cancel your enrollment in a qualified health plan.

On March 28, 2017, you contacted NYSOH to update your application for financial assistance. As a result of subsequent income documentation verification, on April 4, 2017, you were found eligible for Medicaid. Your Medicaid eligibility was effective April 1, 2017. On March 29, 2017, NYSOH issued a

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disenrollment notice stating that your enrollment in your qualified health would end effective April 30, 2017.

You testified that you are seeking an earlier disenrollment date because you now have Medicaid coverage for January 2017, February 2017 and April 2017, when you were still enrolled in your qualified health plan.

If an enrollee is newly eligible for Medicaid, the last day of coverage through their qualified health plan is the day before the Medicaid coverage begins. Since you were determined eligible for Medicaid on April 4, 2017, under the regulations your qualified health plan should have terminated that day. However, NYSOH does not allow for prorated or partial premiums based on the amount of days in a month you were enrolled in a qualified health plan and as such your plan was terminated at the end of the calendar month in which you became eligible for Medicaid.

Therefore, NYSOH properly determined that your plan terminated as of April 30, 2017, and NYSOH's March 29, 2017 disenrollment notice is AFFIRMED.

## **Decision**

The March 29, 2017 disenrollment notice is AFFIRMED.

**Effective Date of this Decision:** October 17, 2017

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

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of April 30, 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.

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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**

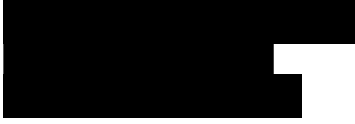
The March 29, 2017 disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of April 30, 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 مجاناً.

### বাংলা (Bengali)

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આવશ્યકતા પૂર્વક સંબંધિત સહાયતા માટે કૃપા કરીને 1-855-355-5777 નંબર પર કોલ કરવાનું વિનય કરવામાં આવેલું છે. આ સહાયતા સેવા સંપૂર્ણપણે મુક્ત છે. અન્ય ભાષાઓમાં આ સહાયતા સેવા ઉપલબ્ધ છે. અન્ય ભાષાઓમાં આ સહાયતા સેવા ઉપલબ્ધ છે. અન્ય ભાષાઓમાં આ સહાયતા સેવા ઉપલબ્ધ છે.

### **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. yEbEtumi 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 איך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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