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

Notice of Decision

Decision Date: August 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018833

[redacted]

Dear [redacted],

On August 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 6, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: August 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018833

[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 and your spouse's enrollment in your qualified health plan ended effective May 31, 2017?

Procedural History

On February 7, 2017, NYSOH issued a notice advising you that your and your spouse's Medicaid coverage through your Local Department of Social Services (LDSS) would end on April 30, 2017.

On March 29, 2017, you updated your household's NYSOH application for financial assistance.

On March 30, 2017, NYSOH issued a notice of eligibility determination, based on the March 29, 2017 application, stating that you and your spouse were eligible for up to $685.00 per month in advance payments of the premium tax credit (APTC) and cost-sharing reductions if you enrolled in a silver level qualified health plan, effective May 1, 2017.

On April 15, 2017, NYSOH issued a notice of enrollment confirmation, based on your plan selection on April 14, 2017, stating that you and your spouse were enrolled in a qualified health plan as of May 1, 2017, and that your APTC would be applied to your monthly premium effective May 1, 2017.

On May 6, 2017, NYSOH issued a disenrollment notice indicating that your and your spouse's coverage in your qualified health plan would end effective May 31, 2017.

On May 10, 2017, you contacted the NYSOH Account Review Unit and appealed the date you and your spouse were disenrolled from your qualified health plan, requesting the disenrollment be made effective May 1, 2017.

On August 15, 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) The record reflects that you and your spouse were enrolled in a qualified health plan through NYSOH and that your and your spouse's coverage was effective as of May 1, 2017.

2) You testified that you paid premiums to your health plan for the month of May 2017.

3) You testified that you received notices in February 2017 from both NYSOH and LDSS advising you that your and your spouse's Medicaid coverage through LDSS was ending, and that you would need to apply with NYSOH.

4) You testified that you contacted LDSS regarding the notice and was advised that you would need to submit an application for yourself and your spouse to NYSOH.

5) You testified that you selected a silver level qualified health plan for yourself and your spouse from enrollment. You went on to testify that you made this selection yourself after researching plans.

6) You testified that on or around May 1, 2017, you received a message from LDSS advising you that you and your spouse were being put back in Medicaid through LDSS until August 31, 2017.

7) You testified that you called LDSS back on or around [redacted] and confirmed that you and your spouse did in fact have Medicaid coverage through LDSS until August 31, 2017.

8) You testified that after confirming with LDSS that your Medicaid coverage through LDSS would be continuing, you contacted NYSOH and advised NYSOH of this information, and requested to disenroll from your and your spouse's qualified health plan for the month of May 2017. Your NYSOH account reflects that this call took place on May 5, 2017.

9) You testified that you and your spouse are seeking an earlier disenrollment date because you and your spouse had Medicaid coverage in May 2017 when you were enrolled in your qualified health plan.

10) You testified neither you nor your spouse used your insurance through your qualified health plan during the month of May 2017.

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)).

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)).

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 your and your spouse's enrollment in your qualified health plan ended effective May 31, 2017.

On March 30, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for APTC of up to $685.00 per month and cost-sharing reductions if you selected a silver level qualified health plan for enrollment, effective May 1, 2017. You subsequently enrolled yourself and your spouse into a qualified health plan.

On May 6, 2017, NYSOH issue a disenrollment notice indicating you and your spouse would be disenrolled from your qualified health plan effective May 31, 2017.

You testified that you are seeking retroactive disenrollment from your and your spouse's qualified health plan effective May 1, 2017.

NYSOH must permit an enrollee to 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 and your spouse's enrollment in a qualified health plan as confirmed in the April 15, 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 and your spouse's enrollment in a qualified health plan as confirmed in the April 15, 2017 enrollment notice was without your knowledge or consent.

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

The record reflects that on May 5, 2017, you contacted NYSOH and requested that you and your spouse be disenrolled from your qualified health plan as you and your spouse were eligible for Medicaid through LDSS until August 31, 2017.

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.

NYSOH terminated your and your spouse's insurance coverage with your qualified health plan effective May 31, 2017, which is the last day of the month following your request.

Since you and your spouse do not qualify to be retroactively disenrolled from your coverage and you did not provide reasonable notice to NYSOH, NYSOH properly determined that your and your spouse's disenrollment from your qualified health plan was effective May 31, 2017.

Therefore, the May 6, 2017, disenrollment notice is AFFIRMED.

Decision

The May 6, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: August 18, 2017

How this Decision Affects Your Eligibility

This decision does not change your and your spouse's disenrollment date. Your and your spouse's enrollment in your qualified health plan ended as of May 31, 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 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).

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 May 6, 2017 disenrollment notice is AFFIRMED.

This decision does not change your and your spouse's disenrollment date. Your and your spouse's enrollment in your qualified health plan ended as of May 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.

□□□□□ (Bengali)

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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.

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