



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

Notice of Decision

Decision Date: January 03, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022639

[REDACTED]

[REDACTED]

On December 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 27, 2017 plan 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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Decision

Decision Date: January 03, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022639

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Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health properly determine that your enrollment in your qualified health plan ended effective September 30, 2017?

Procedural History

On December 18, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for an advanced premium tax credit of up to \$161.00 per month, effective January 1, 2017.

Also on December 18, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in a qualified health plan with the application of your advanced premium tax credit, effective January 1, 2017.

On August 26, 2017, NYSOH received your updated application for financial assistance with health insurance; which included updated income information.

On August 27, 2017, NYSOH issued a notice stating that the income information that was entered into your application did not match what NYSOH received from state and federal data sources and that more information was needed to confirm the information in your application. The notice directed you to submit proof of your household income by September 10, 2017, to confirm your eligibility.

Also on August 27, 2017, NYSOH issued a plan disenrollment notice indicating that coverage in your qualified health plan would end effective September 30, 2017.

On September 9, 2017, you uploaded one income document to your NYSOH account.

On September 11, 2017, NYSOH validated the income documentation and a new application was submitted on your behalf.

On September 12, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective September 1, 2017.

On September 15, 2017, NYSOH issued a plan enrollment notice, based on your plan selection on September 14, 2017, confirming your enrollment in a Medicaid Managed Care plan, effective October 1, 2017.

On September 22, 2017, you contacted the NYSOH Account Review Unit and appealed the date you were disenrolled from your qualified health plan, requesting the disenrollment be made effective August 31, 2017.

On December 27, 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) According to your NYSOH account, you 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. You testified that you did not pay your premium for the last month you had coverage; which was September 2017.
- 3) According to your NYSOH account, you updated your application on August 26, 2017 to indicate that your income had changed.
- 4) You testified that you had to stop working because you became a full-time student and that you currently have no income.
- 5) You testified that you are seeking an earlier disenrollment date because you had Medicaid coverage in September 2017, when you were still

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enrolled in your qualified health plan and you are unable to afford the premium for the month of September 2017.

- 6) You testified you did not use your insurance through your qualified health plan during the month of September 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)).

Medicaid Start Date

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b), Medicaid Eligibility Changes under the Affordable Care Act (ACA) of 2010, 13ADM-03(III)(F)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your qualified health plan ended effective September 30, 2017.

On December 18, 2016 NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$161.00 in advanced premium tax credits per month, effective January 1, 2017. You subsequently enrolled into a qualified health plan.

You testified that you are seeking retroactive disenrollment from your qualified health plan effective August 31, 2017

On August 26, 2017, you submitted an updated application financial assistance to NYSOH; which included an update income. On August 27, 2017, NYSOH issued a notice stating that the information you entered into your application did not match what NYSOH received from state and federal data sources, and this notice further directed you to submit additional income documentation by September 10, 2017 to confirm your eligibility. Also on August 27, 2017, NYSOH

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

On September 9, 2017, you uploaded a letter, dated September 8, 2017, from your employer stating that you were enrolled into school, your hours have been reduced to 4 1/2 hours a week and you make \$16.10 an hour.

On September 11, 2017, NYSOH validated your documentation and an updated application was submitted on your behalf resulting in you being found eligible for Medicaid, effective September 1, 2017. You testified that you are seeking an earlier disenrollment date from your qualified health plan because you had Medicaid coverage in September 2017, while you were still enrolled in your qualified health plan. You further testified that you also cannot afford your premium payment for your qualified health plan for the month of September 2017.

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 September 11, 2017, strictly applying the regulations, your qualified health plan should have terminated the day before on September 10, 2017.

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. Further, under the Medicaid rules, eligibility for Medicaid is made effective the first day of the month in which an individual is determined eligible for Medicaid. In your case that was September 1, 2017, which as a matter of Medicaid Program policy caused a permissible overlap of Medicaid coverage with your qualified health plan for September 2017. As such, your qualified health plan was terminated at the end of the calendar month in which you became eligible for Medicaid.

Therefore, NYSOH properly determined that coverage in your qualified health plan terminated as of September 30, 2017, and NYSOH's August 27, 2017 plan disenrollment notice is AFFIRMED.

Decision

The August 27, 2017 plan disenrollment notice is AFFIRMED.

Effective Date of this Decision: January 03, 2018

How this Decision Affects Your Eligibility

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

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):

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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Summary

The August 27, 2017 plan disenrollment notice is AFFIRMED.

This decision does not change your disenrollment date. Your enrollment in your qualified health plan ended as of September 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)

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 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. ye b&etumi ama wo obi a okyer& 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 אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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