



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

## Notice of Decision

Decision Date: December 21, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022740

[REDACTED]

Dear [REDACTED]

On December 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 10, 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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## Decision

Decision Date: December 21, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022740

[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 your qualified health plan ended effective June 30, 2017?

## Procedural History

On April 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective June 1, 2017.

Also on April 18, 2017, NYSOH issued a notice of plan enrollment, stating that you were enrolled in a qualified health plan, CareConnect EPO Platinum ST INN Pediatric Dental Dep (CareConnect), effective January 1, 2017.

On August 10, 2017, NYSOH issued a disenrollment notice indicating your coverage with CareConnect would end effective June 30, 2017 because you did not pay your insurance bill by the payment deadline.

On September 14, 2017, incident # [REDACTED] was created. That incident reflects that you requested NYSOH honor the June 30, 2017 disenrollment date as stated in the August 10, 2017 disenrollment notice.

On September 15, 2017, incident # 2 [REDACTED] was updated and closed. The incident reflects that NYSOH determined your request to honor the June 30,

2017 disenrollment date was invalid because the NYSOH system reflected a July 31, 2017 disenrollment date.

On September 22, 2017, you contacted the NYSOH Account Review Unit and requested an appeal to honor your end date with CareConnect as of June 30, 2017, as stated in the August 10, 2017 disenrollment notice.

On December 6, 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 were enrolled in a qualified health plan, CareConnect, through NYSOH and that your coverage was effective as of June 1, 2017.
- 2) On August 10, 2017, NYSOH issued a disenrollment notice stating that your coverage with CareConnect ended June 30, 2017 because you did not pay your premium.
- 3) Your NYSOH account shows your coverage with CareConnect ended July 31, 2017.
- 4) You testified that you were not sent a notice stating that your coverage with CareConnect ended July 31, 2017.
- 5) Your NYSOH account does not contain a disenrollment notice stating that your end date with CareConnect was July 31, 2017 or a notice stating that you had been reenrolled into CareConnect for July 2017.
- 6) You testified that you paid premiums to CareConnect for the months of June, July, August, and September.
- 7) You testified that CareConnect did not cover your medical care and prescription expenses for the months of July, August, and September, and that you paid for your medical care and prescriptions out of pocket for these months.
- 8) You testified that you are seeking a disenrollment date of June 30, 2017, because CareConnect will not reimburse you for the month of July 2017 since the NYSOH system reflects a disenrollment date of July 31, 2017.

- 9) You testified that you did not know that your NYSOH account listed a disenrollment date of July 31, 2017 until you contacted CareConnect for reimbursement of your premiums.

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-

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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 enrollment in your qualified health plan ended effective June 30, 2017.

On April 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost, effective June 1, 2017. You enrolled into a qualified health plan, CareConnect.

On August 10, 2017 NYSOH issued a disenrollment notice indicating your coverage with CareConnect ended effective June 30, 2017.

However, your NYSOH account reflects that your coverage with CareConnect actually ended as of July 31, 2017.

You testified that you are seeking a disenrollment date of June 30, 2017, because CareConnect will not reimburse you for the month of July 2017 since the NYSOH system reflects a disenrollment date of July 31, 2017.

NYSOH must permit an enrollee to be retroactively disenrolled 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.

You testified that you were not sent a notice stating that your coverage with CareConnect ended July 31, 2017. Furthermore, your NYSOH account does not

contain a disenrollment notice stating that your end date with CareConnect was July 31, 2017 or a notice stating that you had been reenrolled into CareConnect for July 2017. There is also no evidence in the record that you requested or were granted coverage through CareConnect for the month of July 2017.

Therefore, your enrollment in a qualified health plan for the month of July 2017 was unintentional, inadvertent, or the result of an error of an officer, employee, or agent of NYSOH, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities. Therefore, NYSOH must permit you to retroactively terminate or cancel your enrollment in a qualified health plan.

Accordingly, NYSOH's August 10, 2017, disenrollment notice is AFFIRMED since it stated the end date of your enrollment in a qualified health plan through CareConnect was June 30, 2017.

Your case is RETURNED to NYSOH to update their system to reflect the disenrollment date of June 30, 2017, that is properly stated in the August 10, 2017 disenrollment notice.

## **Decision**

The August 10, 2017 disenrollment notice is AFFIRMED.

Your case is RETURNED to NYSOH to update their system to reflect the disenrollment date of June 30, 2017, that is properly stated in the August 10, 2017 disenrollment notice.

**Effective Date of this Decision:** December 21, 2017

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

Your qualified health plan ended as of June 30, 2017.

Your case is being sent back to NYSOH to disenroll you accordingly.

## **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.

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).

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

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## **Summary**

The August 10, 2017 disenrollment notice is AFFIRMED.

Your case is RETURNED to NYSOH to update their system to reflect the disenrollment date of June 30, 2017, that is properly stated in the August 10, 2017 disenrollment notice.

Your case is being sent back to NYSOH to disenroll you accordingly.

## **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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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 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 e tumi ama wo obi a okyer e 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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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