



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

## Notice of Decision

Decision Date: January 19, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024760

[REDACTED]

[REDACTED]

On January 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 18, 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).

This page intentionally left blank.



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

## Decision

Decision Date: January 19, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024760

[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 the Essential Plan ended effective September 30, 2017?

## Procedural History

According to your NYSOH account, you were initially found eligible for and enrolled in the Essential Plan on November 1, 2016. On October 18, 2017, you called NYSOH and requested that your Essential Plan coverage be cancelled. That same day, you were advised that your coverage would be retroactively terminated as of September 30, 2017.

Also on October 18, 2017, NYSOH issued a disenrollment notice indicating your coverage in the Essential Plan would end effective October 31, 2017.

On October 19, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for health coverage through NYSOH because you no longer wanted to receive coverage. This eligibility was effective December 1, 2017.

On November 22, 2017, you contacted the NYSOH Account Review Unit and appealed the date you were disenrolled from the Essential Plan, requesting the disenrollment be made effective November 13, 2017.

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).

On January 12, 2018, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. Your request to amend the appeal to change your Essential Plan end date to October 31, 2017, was granted and testimony was received. The record was held open to January 27, 2018, for you to submit supporting documents.

On January 12, 2018, you submitted your coverage and benefits statement from your employer-sponsored insurance (ESI), dated January 12, 2018. This document was made part of the record as "Appellant's Exhibit A." The record closed on that day.

## **Findings of Fact**

A review of the record supports the following findings of fact:

- 1) You testified, and submitted documentation to show, that you became eligible for and enrolled in health insurance through your employer as of October 14, 2017 (see Appellant's Exhibit A, p. 2).
- 2) You testified that sometime in October 2017, you contacted NYSOH to disenroll from your Essential Plan through NYSOH as of October 31, 2017. You believe you told the NYSOH representative that your ESI began on November 1, 2017.
- 3) According to a telephone recording, dated October 18, 2017, you called NYSOH and requested to be disenrolled from your health plan because you were eligible for and enrolled in ESI as of October 1, 2017. At that time, the NYSOH representative advised you that you would be retroactively terminated from your health coverage as of September 30, 2017, and that it was important that the effective date of your ESI was accurate. The NYSOH representative further stated that you would need to submit any claims for the month of October 2017 to your ESI. You responded affirmatively.
- 4) According to the Enrollment History Tab in your NYSOH account, your Essential Plan coverage ended September 30, 2017.
- 5) You testified that you learned that your ESI was not to begin on October 1, 2017, but rather at a later date.
- 6) You testified that you are seeking your Essential Plan to be reinstated for the month of October 2017, because you have a medical bill from services received on or about October 9, 2017, at which time you had no health insurance coverage.

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

## **Applicable Law and Regulations**

### Essential Plan

For individuals seeking enrollment or disenrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment or disenrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

### 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)).

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 permits a qualified health plan to retroactively 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 Essential Plan ended effective September 30, 2017.

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).

According to your NYSOH account, you were initially found eligible for and enrolled in the Essential Plan on November 1, 2016. On October 18, 2017, you called NYSOH and requested that your Essential Plan coverage be cancelled. That same day, you were advised that your coverage would be retroactively terminated to October 1, 2017.

On October 18, 2017, NYSOH issued a disenrollment notice indicating you would be disenrolled from your Essential Plan effective October 31, 2017. However, according to your NYSOH account, your Essential Plan coverage ended September 30, 2017.

Generally, NYSOH may retroactively disenroll a person from their Essential Plan if the enrollee is no longer eligible for coverage through NYSOH. In your case, you called NYSOH on October 18, 2017, and requested that you be disenrolled from your Essential Plan because you were eligible for and enrolled in ESI as of October 1, 2017. During that same telephone call, the NYSOH representative advised you that you would be disenrolled from that health plan as of September 30, 2017 and that you should submit any claims for the month of October 2017 to your ESI.

Since there is no indication in the record that your disenrollment from the Essential Plan, as confirmed in the October 18, 2017 telephone call, was unintentional, inadvertent, or the result of the error or misconduct of an agent of NYSOH, its instrumentalities, nor was the disenrollment without your knowledge or consent, by this Decision, it is concluded that NYSOH properly terminated your insurance coverage with your Essential Plan effective September 30, 2017.

However, because NYSOH's October 18, 2017 disenrollment notice improperly states that you were disenrolled effective October 31, 2017, it is MODIFIED to state that your coverage in your Essential Plan ended on September 30, 2017.

Likewise, the October 19, 2017 eligibility determination notice is MODIFIED to state that, effective October 1, 2017, you were no longer eligible for health coverage through NYSOH.

According to your NYSOH account, your Essential Plan coverage ended September 30, 2017. Therefore, no further action is required by NYSOH at this time.

## **Decision**

The October 18, 2017 disenrollment notice is MODIFIED to state that your coverage in your Essential Plan ended on September 30, 2017.

The October 19, 2017 eligibility determination notice is MODIFIED to state that, effective October 1, 2017, you were no longer eligible for health coverage through NYSOH.

No further action is required by NYSOH at this time.

**Effective Date of this Decision:** January 19, 2018

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

By this Decision, your enrollment in your Essential Plan ended on 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 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 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 October 18, 2017 disenrollment notice is MODIFIED to state that your coverage in your Essential Plan ended on September 30, 2017.

The October 19, 2017 eligibility determination notice is MODIFIED to state that, effective October 1, 2017, you were no longer eligible for health coverage through NYSOH.

By this Decision, your enrollment in your Essential Plan ended on September 30, 2017.

No further action is required by NYSOH at this time.

## **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।

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).

## **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&etumi 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 אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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).