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

Notice of Decision

Decision Date: February 22, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025614

[redacted]

[redacted]

On February 15, 2018, your Authorized Representative appeared by telephone at a hearing on your appeal of NY State of Health's November 22, 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: February 22, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025614

[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 (QHP) ended effective December 31, 2017?

Procedural History

On December 15, 2016, NYSOH issued an enrollment notice confirming your enrollment in a QHP, with a monthly premium of $465.52 after the application of your tax credit, beginning January 1, 2017.

On October 24, 2017, NYSOH issued a renewal notice stating that it was time to renew your health insurance. The notice stated that, based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help for paying for your health coverage, and that you needed to update your account by December 15, 2017 or you would be in danger of losing your coverage.

On November 22, 2017, NYSOH issued a disenrollment notice indicating your coverage in your QHP would end effective December 31, 2017.

On November 28, 2017, you submitted an updated application for financial assistance.

On November 29, 2017, NYSOH issued a notice, based on your November 28, 2017 application, stating that additional information was required to confirm your eligibility. The notice requested that you provide proof of household income by December 13, 2017.

On November 29, 2017, you uploaded proof of household income to your NYSOH account.

On November 30, 2017, NYSOH verified your submitted proof of household income.

Also, on November 30, 2017, NYSOH updated your application and re-ran your eligibility based upon your submitted proof of household income.

On December 1, 2017, NYSOH issued a notice of eligibility redetermination, based on the November 30, 2017 application, stating that you were eligible for Medicaid, effective November 1, 2017.

Also on December 1, 2017, NYSOH issued a notice of enrollment confirmation, based on a plan selection made November 30, 2017, stating that you were enrolled in a Medicaid Managed Care plan, effective January 1, 2018.

On December 11, 2017, you spoke to NYSOH's Account Review Unit and appealed the date you were disenrolled from your QHP, requesting the disenrollment be made effective October 31, 2017.

On February 15, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [redacted] acted as your Authorized Representative and assisted you with your testimony. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) Your Authorized Representative testified that you are appealing to have your disenrollment from your QHP be made effective October 31, 2017.

2) Your Authorized Representative testified that you were enrolled into a QHP in January of 2017.

3) Your Authorized Representative testified that you submitted an updated application to NYSOH on November 28, 2017.

4) Your Authorized Representative testified that she enrolled you into a Medicaid Managed Care plan in November.

5) Your Authorized Representative testified that you received medical care in November and December of 2017.

6) Your Authorized Representative testified that you made full premium payments of $465.52 to the QHP in both November and December of 2017.

7) Your Authorized Representative testified that the QHP agreed to reimburse you for the premium payments made in November and December of 2017 if NYSOH confirmed that you were disenrolled from the plan during those months.

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

Applicable Law and Regulations

Termination of a QHP — Effective Date

NYSOH must permit an enrollee to terminate his coverage with a QHP, including when an enrollee obtains minimum essential coverage (45 CFR § 155.430(b)(1)(i)).

If an enrollee is newly eligible for Medicaid, Child Health Plus, or the Essential Plan, the last day of enrollment in the QHP is the day before the individual is determined eligible for Medicaid, Child Health Plus, or the Essential Plan (45 CFR § 155.430(d)(2)(iv)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your QHP ended effective December 31, 2017.

On December 15, 2016, NYSOH issued an enrollment notice confirming your enrollment in a QHP beginning January 1, 2017.

On November 22, 2017, NYSOH issued a disenrollment notice indicating your coverage in your QHP would end effective December 31, 2017.

On November 30, 2017, you were found eligible for Medicaid.

NYSOH must permit an enrollee to terminate his QHP coverage with appropriate notice to NYSOH. If the enrollee is newly eligible for Medicaid, the last day of coverage through the QHP is the day before he was determined eligible for Medicaid.

Because you were found newly eligible for Medicaid on November 30, 2017, your QHP coverage, previously set to end effective December 31, 2017, should have terminated as of November 29, 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 QHP and as such your plan was terminated at the end of the calendar month in which you became eligible for Medicaid, which in this instance was November.

Therefore, the November 22, 2017 disenrollment notice is MODIFIED to state that you were disenrolled from your QHP as of November 30, 2017.

Your case is RETURNED to NYSOH to retroactively disenroll you from your QHP for the month of December 2017.

Decision

The November 22, 2017 disenrollment notice is MODIFIED to state that your disenrollment from your QHP was effective November 30, 2017.

Your case is RETURNED to NYSOH to retroactively disenroll you from your QHP for the month of December 2017.

Effective Date of this Decision: February 22, 2018

How this Decision Affects Your Eligibility

Your enrollment in your QHP should have ended as of November 30, 2017. You remain eligible for Medicaid as of November 1, 2017.

Your case is being sent back to NYSOH to disenroll you from your QHP for the month of December 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.

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):

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- 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 November 22, 2017 disenrollment notice is MODIFIED to state that your disenrollment from your QHP was effective November 30, 2017.

Your enrollment in your QHP should have ended as of November 30, 2017. You remain eligible for Medicaid as of November 1, 2017.

Your case is being sent back to NYSOH to disenroll you from your QHP for the month of December 2017.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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.

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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई नि:शुल्क 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.

اردو (Urdu)

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.

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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