



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

Notice of Decision

Decision Date: February 1, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000026082

[REDACTED]

[REDACTED]

On January 23, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 21, 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
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Decision

Decision Date: February 1, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000026082

[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 bronze level qualified health plan ended effective January 1, 2018?

Procedural History

On September 22, 2017, NYSOH received your initial application for health insurance. That day, a preliminary eligibility determination was prepared stating that you were eligible for up to \$182.00 per month in advance payments of the premium tax credit (APTC), effective November 1, 2017. Also on that day, you enrolled into a qualified health plan.

On September 23, 2017, NYSOH issued a notice of plan enrollment, stating that you were enrolled in a bronze level qualified health plan, effective November 1, 2017.

On October 1, 2017, NYSOH issued an eligibility determination notice, based on your September 22, 2017 application, stating that you were eligible for up to \$182.00 per month in APTC, effective November 1, 2017.

On November 21, 2017, NYSOH issued a notice indicating your coverage with your bronze level qualified health plan would end effective January 1, 2018 because you asked NYSOH to end your coverage on November 20, 2017.

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On December 19, 2017, you contacted the NYSOH Account Review Unit and requested an appeal insofar as you were not disenrolled from your bronze level qualified health plan before January 1, 2018.

On January 23, 2018, 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) On September 22, 2017, you contacted NYSOH to apply for health insurance coverage.
- 2) You testified that when you selected a plan for enrollment on September 22, 2017, you asked to be enrolled in a qualified health plan that did not have any hospital costs.
- 3) During the hearing, you gave the Hearing Officer permission to listen to phone calls that you had with NYSOH. A review of the phone call that you had on September 22, 2017, indicates that you were calling to submit an application for financial assistance and enroll into a qualified health plan. A NYSOH employee assisted you in filing out an application for health insurance coverage and choosing a plan. A representative was discussing the bronze level qualified health plan with you. You stated that you did not want that plan because it had 50% deductible for hospital costs. You were advised by the NYSOH representative that the bronze level qualified health plan did not have a deductible for hospital costs. Based on the representative's statement, you chose to enroll in the bronze level qualified health plan.
- 4) You were enrolled in a bronze level qualified health plan, effective November 1, 2017.
- 5) You testified that you received a packet from your health plan and realized that what the plan entails was not what the NYSOH representative told you.
- 6) On November 6, 2017, you placed a phone call to NYSOH. A review of that phone calls indicates that you were calling to renew your health insurance for 2018 and to fix your enrollment because of the hospital costs associated with your current health plan. The NYSOH representative advised you that you could not change your plan or renew at that time and to call back during the renewal period.

- 7) On November 20, 2017, you placed a phone call to NYSOH. A review of that phone call indicates that you were calling to renew and change your plan. You asked to change your plan from the bronze level qualified health plan to a silver level qualified health plan.
- 8) You testified that you would not have chosen the bronze level qualified health plan had you known there was hospital deductible costs associated with the plan.
- 9) You testified that you paid the premiums for your bronze level qualified health plan.
- 10) You testified that you did not use your bronze level qualified health plan in November or December 2017.
- 11) You testified that you are seeking a disenrollment date of November 30, 2017 your bronze level qualified.

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)).

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in your bronze level qualified health plan ended effective January 1, 2018.

On September 22, 2017, you contacted NYSOH to apply for health insurance coverage. That day, you enrolled into a bronze level qualified health plan, effective November 1, 2017.

On November 20, 2017, you contacted NYSOH to end your coverage in your bronze level qualified health plan.

On November 21, 2017, NYSOH issued a notice stating that you had been disenrolled from your bronze level qualified health plan, effective January 1, 2018.

You testified that you are seeking retroactive disenrollment from your bronze level qualified health plan.

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

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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 when you selected a plan for enrollment on September 22, 2017, you asked to be enrolled in a qualified health plan that did not have any hospital costs. A review of the phone call that you had on September 22, 2017, confirms your testimony. During the phone call, you stated that you did not want a bronze level qualified health plan because it had 50% deductible for hospital costs. You were advised by the NYSOH representative that the bronze level qualified health plan did not have a deductible for hospital costs and based on the representative's statement, you chose to enroll in the bronze level qualified health plan. You testified that you would not have chosen the bronze level qualified health plan had you known there was hospital deductible costs associated with the plan. You testified that you received a packet from your health plan and realized that what the plan entails was not what the NYSOH representative told you.

You subsequently called NYSOH to change your enrollment on November 6, 2017 and November 20, 2017 to a plan that better suited your needs.

Therefore, the record reflects that your enrollment in the bronze level qualified health plan was unintentional and the result of misinformation given to you by an agent of NYSOH. Since you contacted NYSOH within 60 days of your incorrect enrollment in a bronze level qualified health plan, NYSOH must permit you to retroactively terminate or cancel your enrollment in your qualified health plan.

Accordingly, the November 21, 2017 disenrollment notice is MODIFIED to state that your disenrollment in your bronze level qualified health plan is effective as of November 30, 2017.

Your case is RETURNED to NYSOH to disenroll you from your bronze level qualified health plan for the month of December 2017.

Decision

The November 21, 2017 disenrollment notice is MODIFIED to state that your disenrollment in your bronze level qualified health plan is effective as of November 30, 2017.

Your case is RETURNED to NYSOH to disenroll you from your bronze level qualified health plan for the month of December 2017.

Effective Date of this Decision: February 1, 2018

How this Decision Affects Your Eligibility

Your bronze level qualified health plan ended as of November 30, 2017.

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

Your enrollment in your silver level qualified health plan, effective as of January 1, 2018, is not affected by this decision.

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 November 21, 2017 disenrollment notice is MODIFIED to state that your disenrollment in your bronze level qualified health plan is effective as of November 30, 2017.

Your bronze level qualified health plan ended as of November 30, 2017.

Your case is RETURNED to NYSOH to disenroll you from your bronze level qualified health plan for the month of December 2017.

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

Your enrollment in your silver level qualified health plan, effective as of January 1, 2018, is not affected by this decision.

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 1-855-355-5777번으로 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&etumi ama wo obi a okyerε 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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