



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

Notice of Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000028933

[REDACTED]

[REDACTED],

On April 16, 2018, you both appeared by telephone at a hearing on your appeal of NY State of Health's February 15, 2018 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000028933



Issue

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

Did NY State of Health properly determine that you and your spouse's enrollment in your qualified health plan terminated as of February 28, 2018?

Procedural History

According to your NY State of Health (NYSOH) account, in December 2017, you and your spouse were determined eligible to purchase a qualified health plan at full cost through NYSOH. You and your spouse were enrolled into a full pay qualified health plan, effective January 1, 2018.

On February 14, 2018, NYSOH received your updated application for financial assistance with health insurance, in which you indicated that you and your spouse no longer needed health insurance through NYSOH. That day a preliminary eligibility determination was prepared stating that you and your spouse were no longer eligible to enroll in health insurance through NYSOH, effective March 1, 2018, and that you and your spouse were disenrolled from your qualified health plan as of February 28, 2018.

Also on February 14, 2018, you contacted the NYSOH's Account Review Unit and appealed the date that you and your spouse were disenrolled from your qualified health plan, requesting that your and your spouse's disenrollment be made effective January 31, 2018.

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On February 15, 2018, NYSOH issued a discontinuance notice, based on your February 14, 2018 application, stating that you and your spouse were no longer eligible to enroll in health insurance through NYSOH, effective March 1, 2018. This notice further stated that this was because you and your spouse no longer wanted to receive coverage.

Also on February 15, 2018, NYSOH issued a plan disenrollment notice stating that you and your spouse were no longer enrolled in your qualified health plan as of February 28, 2018.

On April 16, 2018, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and the record was closed at the end of the hearing.

Findings of Fact

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

- 1) You testified that you started a new job sometime in early February 2018.
- 2) You testified that you and your spouse became eligible for health insurance through your employer on February 1, 2018.
- 3) You testified that you contacted NYSOH on or around February 15, 2018 to cancel your and your spouse's coverage through NYSOH.
- 4) According to your NYSOH account, you updated your NYSOH account on February 14, 2018 to indicate that you and your spouse no longer needed health insurance through NYSOH.
- 5) On February 15, 2018, NYSOH issued a plan disenrollment notice stating that your and your spouse's enrollment in your qualified health plan coverage would be terminate as of February 28, 2018.
- 6) You testified that you paid a premium to your qualified health plan for the months of January 2018 and February 2018.
- 7) You testified that you and your spouse did not use your qualified health plan coverage in the months of January 2018 and February 2018.
- 8) You testified that you are seeking retroactive disenrollment from your qualified health plan as of January 31, 2018, because you and your spouse have coverage through your employer starting as of February 1, 2018.

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.

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(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 and your spouse's enrollment in your qualified health plan terminated as of February 28, 2018.

The record indicates that you and your spouse were enrolled in a full pay qualified health plan, effective January 1, 2018.

You testified that you started a new job in early February 2018 and that you and your spouse were offered health insurance through your employer, which began as of February 1, 2018. As a result, you testified that you contacted NYSOH on or around February 15, 2018, and indicated that you and your spouse no longer needed coverage through NYSOH. Your NYSOH account shows that you updated your NYSOH account on February 14, 2018 to indicate that you and your spouse no longer needed health insurance through NYSOH. Subsequently, NYSOH issued a plan disenrollment notice stating that your and your spouse's qualified health plan coverage would terminate as of February 28, 2018.

However, you testified that you are seeking retroactive disenrollment from your and your spouse's qualified health plan as of January 31, 2018.

NYSOH must permit an enrollee to be retroactively disenroll 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.

There is no indication in the record that your and your spouse's enrollment in a qualified health plan, as confirmed in the December 16, 2017 plan enrollment notice, was unintentional, inadvertent, or erroneous, nor was your enrollment in a qualified health plan 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. Furthermore, there is

no indication that you and your spouse's enrollment in a qualified health plan was without your knowledge or consent.

Therefore, there is no basis to find that NYSOH must permit you and your spouse to retroactively terminate or cancel your enrollment in a qualified health plan.

However, enrollees must be allowed to terminate their coverage with a qualified health plan as of the date they specify if they provide reasonable notice to NYSOH or to their health plan. Reasonable notice is defined as at least 14 days prior to the requested termination date.

The record reflects that on February 14, 2018 you updated your NYSOH account to indicate that you and your spouse no longer needed health insurance through NYSOH. Subsequently, NYSOH issued a plan disenrollment notice, on February 15, 2018, which indicates that NYSOH disenrolled you and your spouse from health insurance coverage as of February 28, 2018

Since you do not qualify to be retroactively disenrolled from your coverage and you did not provide reasonable notice to NYSOH of at least 14 days prior to the requested termination date, NYSOH properly determined that you and your spouse were terminated from your qualified health plan coverage as of February 28, 2018.

Therefore, the February 15, 2018 plan disenrollment notice is **AFFIRMED** because it properly ended your and your spouse's qualified health plan coverage through NYSOH as of February 28, 2018.

Decision

The February 15, 2018 plan disenrollment notice is **AFFIRMED** because it properly ended your and your spouse's qualified health plan coverage through NYSOH as of February 28, 2018.

Effective Date of this Decision: April 19, 2018

How this Decision Affects Your Eligibility

This decision does not change your or your spouse's disenrollment date. Your and your spouse's enrollment in your qualified health plan ended as of February 28, 2018.

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 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):

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

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The February 15, 2018 plan disenrollment notice is AFFIRMED because it properly ended your and your spouse's qualified health plan coverage through NYSOH as of February 28, 2018.

This decision does not change your or your spouse's disenrollment date. Your and your spouse's enrollment in your qualified health plan ended as of February 28, 2018.

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&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.

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