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

Notice of Decision

Decision Date: October 4, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000007761, AP000000010610

[redacted]

Dear [redacted]

On August 30, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's March 9, 2016 eligibility determination notice and March 9, 2016 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: October 4, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000007761, AP000000010610

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly deny you and your spouse a special enrollment period to change your health plan outside of the open enrollment period for 2016?
>
> Did NYSOH properly disenroll your daughter [redacted] from her Medicaid Managed Care plan due to having third party health insurance effective March 31, 2016?

Procedural History

On December 11, 2015, NYSOH received your household's application for financial assistance with your health insurance.

On December 12, 2015, NYSOH issued a notice of eligibility determination that stated that you and your spouse were eligible to receive an advance premium tax credit of up to $518.00 per month, as well as eligible to receive cost-sharing reductions effective January 1, 2016. The determination further found your two daughters no longer eligible for Medicaid, however their coverage would continue until July 31, 2016. You were asked to come back between June 16, 2016, and July 16, 2016 to update the information in your account. The determination was based on your attested household income of $49,560.00.

That same day an enrollment confirmation notice was issued confirming you and your spouse's enrollment in a Silver level qualified health plan with a cost of

$401.64 per month with a family deductible of $1,600.00 per person and $3,200.00 per group effective January 1, 2016. It further confirmed your two children's enrollment in their Medicaid Managed Care plans effective October 1, 2015.

On March 8, 2016, NYSOH's Account Review Unit received your written request for an appeal on the issue of a denial of a special enrollment period (See Document: [redacted]).

On March 9, 2016, NYSOH issued a notice of eligibility determination stating you and your spouse were eligible to receive an advance premium tax credit of up to $518.00 per month, as well as eligible to receive cost-sharing reductions effective January 1, 2016. The notice further stated you did not qualify to select a health plan outside of the open enrollment period for 2016. The determination was based on your attested household income of $49,560.00.

That same day a disenrollment notice was issued terminating your daughter's [redacted] coverage in her Medicaid Managed Care plan effective March 31, 2016.

On June 16, 2016, a renewal notice was issued stating there was not enough information in your account to determine whether you and your household still qualified for financial assistance. You were asked to update the information in your NYSOH account by July 15, 2016, or the financial assistance you were currently receiving could end.

On June 23, 2016, NYSOH's received your household's updated application for financial assistance.

On June 24, 2016, an eligibility determination notice was issued finding you and your household eligible to enroll in the Essential Plan effective August 1, 2016. The determination was based on your attested household income of $47,020.00.

That same day an enrollment confirmation notice was issued confirming you and your household's enrollment in the Essential Plan starting August 1, 2016. The notice stated your daughter still needed to pick a health plan or her coverage in the Essential Plan would not begin.

That same day a disenrollment notice was issued terminating you and your spouse's enrollment in your Silver level qualified health plan effective July 31, 2016. It further terminated your one daughter's [redacted] enrollment in her Medicaid Managed Care plan effective July 31, 2016. The determination stated your other daughter's [redacted] enrollment in her Medicaid Fee-For-Service would be terminated effective July 31, 2016.

On June 29, 2016, you contacted NYSOH's Account Review Unit to appeal your daughter's [redacted] disenrollment from her Medicaid Managed Care plan effective March 31, 2016, as she had an unpaid medical bill she incurred in the month of May, 2016.

On August 30, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) The record indicates that you submitted your initial application for 2016 health insurance coverage on December 11, 2015.

2) You expect to file your 2015 federal income tax return as married filing jointly, and claim both of your daughters as dependents.

3) According to the December 11, 2015, application you attested to an expected annual household income of $49,560.00. You testified at the time you submitted your application this income was an accurate reflection of your expected income for the 2016 tax year.

4) The record reflects you enrolled you and your spouse in a Silver level Premier Plus Plan, for a couple, with an annual deductible of $1,600.00 for an individual and $3,200.00 per group effective January 1, 2016.

5) You testified that you believe you relied on incorrect information provided by NYSOH regarding the annual deductible you would be responsible for a Silver level Premier Plus qualified health plan.

6) You testified that it is your belief you would not have selected the Premier Plus Silver level qualified health plan had you known that the deductible was in fact $3,200.00 for a group, and that you could not use the $1,600.00 individual deductible for your own medical expenses only.

7) You testified that you want the plan you selected to reflect an individual deductible in the amount of $1,600.00, not, $3,200.00, or the ability to be granted a special enrollment period to enroll in a new plan with a lower deductible.

8) You provided a one page print out of the NYSOH web page demonstrating a comparison of the plans that were offered to you. The page shows a "Plan Comparison" of a Silver level, Premier Plus qualified health plan with

an annual deductible of $2,000.00 per person;$4,000.00 per group. Next to this plan is a Silver level Premier plan with a $2,000.00 per person; $4,000.00 per group. You uploaded this documentation on March 10, 2016 (Appellant's Exhibit A, [redacted].

9) You provided a copy of a one page print out of the NYSOH web page demonstrating a "Plan Detail." The web page shows the annual deductible of a couple being $2,000.00 per person, and $4,000.00 per group. You uploaded this documentation on March 10, 2016 (Appellant's Exhibit B, [redacted].

10) You testified that you had reached the individual deductible of $1,600.00 to date.

11) The record reflects you and your household were found eligible for and enrolled in the Essential Plan with no annual deductible effective August 1, 2016.

12) You testified you are also seeking to have your daughter [redacted] re-enrolled into her Medicaid Managed Care plan effective April 1, 2016.

13) Your daughter was found eligible for Medicaid August 1, 2015, and enrolled in a Medicaid Managed Care plan effective October 1, 2015.

14) You testified your daughter incurred medical costs in the month of April, 2016 which were not covered by her doctor, as he does not accept Medicaid-Fee-For service.

15) You testified that your daughter had third party health insurance through her school for a travel abroad program for the month of March, 2016, which you informed NYSOH of on March 8, 2016.

16) The record reflects a NYSOH agent deleted your daughter's enrollment in her Medicaid Managed Care plan on March 8, 2016.

17) You testified that you believed this disenrollment to be only temporary, and that your daughter would be re-enrolled in her Medicaid Managed Care plan after returning from her trip at the end of March, 2016.

18) You submitted documentation of the proof that your daughter's third party health insurance had ended April 3, 2016. The documentation you provided was in the form of a one-page letter dated March 16, 2016 from her school and uploaded on June 17, 2016, to your NYSOH account (See Appellant's Exhibit C, [redacted].

19) Your application states that you live in Rockland County, New York.

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

Applicable Law and Regulations

Enrollment in a Qualified Health Plan

NY State of Health (NYSOH) must provide annual open enrollment periods during which time qualified individuals may enroll in a qualified health plan (QHP) and enrollees may change QHPs (45 CFR § 155.410(a)(1)).

For the benefit year beginning on January 1, 2016, the annual open enrollment period began on November 1, 2015, and extended through January 31, 2016 (45 CFR § 155.410(e)(2)).

Special Enrollment Periods

After each open enrollment period ends, NYSOH provides special enrollment periods to qualified individuals. During a special enrollment period, a qualified individual may enroll in a QHP, and an enrollee may change their enrollment to another plan. This is generally permitted when one of the following triggering events occur:

> The qualified individual's or his or her dependent's, enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange; or a non-Exchange entity providing enrollment assistance or conducting enrollment activities; or

(45 CFR § 155.420(d)).

Generally, if a triggering life event occurs, the qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP (45 CFR § 155.420(c)(1)).

Medicaid for Adults between the Ages of 19 and 65

Medicaid through NYSOH can be provided to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State

plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); N.Y. Soc. Serv. Law § 366(1)(b)).

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

Timely Notice of Medicaid Eligibility

When an individual applies for insurance through NYSOH, NYSOH must determine that person’s eligibility promptly and without undue delay (45 CFR § 155.310(e)(1); 42 CFR § 435.1200(b)(3)(iii)).

To assess whether an eligibility determination was untimely, NYSOH must base the time period from the date of application to the date NYSOH notifies the applicant of its decision (45 CFR § 155.310(e)(2)). However, if the applicant submits an incomplete application or there is not sufficient information for NYSOH to make an eligibility determination, then NYSOH must notify that applicant that more information is needed to complete the application (45 CFR § 155.310(k)(1)).

NYSOH must provide Medicaid applicants notice of their eligibility determination within 45 days from the date of the application (42 CFR § 435.912).

Legal Analysis

The first issue under review is whether NYSOH properly denied you and your spouse a special enrollment period to change your health plan outside of the open enrollment period for 2016.

NYSOH provided an open enrollment period from November 1, 2015 until January 31, 2016.

The record indicates that you submitted a complete application for financial assistance to NYSOH on December 11, 2015. A notice of eligibility determination was then issued on December 12, 2015, stating you and your spouse were eligible to receive an advance premium tax credit of up to $518.00 per month, as well as eligible to receive cost-sharing reductions effective January 1, 2016. The determination was based on your attested household income of $49,560.00.

You subsequently enrolled you and your spouse in a Silver level Premier Plus plan, for a couple, with an annual deductible of $1,600.00 per person and $3,200.00 per group effective January 1, 2016

On March 8, 2016, NYSOH's Account Review Unit received a written request for an appeal on the issue of a denial of a special enrollment period to change your health plan to one with a lower cost annual deductible. The reason for your appeal based on your written letter states you had relied on the information that was presented to you by a NYSOH website when you had enrolled in a Silver level Premier Plus plan on December 11, 2015.

Your request for a plan change was received after January 31, 2016, the end of the open enrollment period for 2016. Therefore you did not complete your new application for a plan change during the open enrollment period.

Once the annual open enrollment period ends, a health plan enrollee must qualify for a special enrollment period in order to enroll in, or change to another health plan offered in NYSOH. In order to qualify for a special enrollment period, a person must experience a triggering event.

A special enrollment period can be granted if a qualified individual's enrollment or non-enrollment into a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of NYSOH or its instrumentalities as evaluated and determined by the NYSOH.

During your telephone hearing, you testified that you relied on incorrect information provided by NYSOH regarding the annual deductible you would be responsible for with your Silver level Premier Plus plan. It is your belief you would not have selected the Premier Plus Silver level qualified health plan had you

known that the deductible was in fact $3,200.00 for a group, and that you could not use the $1,600.00 individual deductible for your own medical expenses only.

In support of your position, you provided a one page print out of the NYSOH web page demonstrating a comparison of the plans that were offed to you. You uploaded this documentation on March 10, 2016. The page shows a “Plan Comparison” of a Silver level, Premier Plus qualified health plan with an annual deductible of $2,000.00 per person;$4,000.00 per group. Next to this plan is a Silver level Premier plan with a $2,000.00 per person; $4,000.00 per group. (Appellant’s Exhibit A, [redacted].

Additionally on March 10, 2016, you provided a copy of a one page print out of the NYSOH web page demonstrating a “Plan Detail.” The web page shows the annual deductible of a couple being $2,000.00 per person, and $4,000.00 per group. (Appellant’s Exhibit B, [redacted]. You testified that you had reached the individual deductible of $1,600.00 to date.

The record supports you did in fact enroll in the Silver level Premier Plus plan. A December 12, 2015, enrollment confirmation notice was issued confirming you and your spouse’s enrollment in a Silver level Premier Plus qualified health plan with a deductible of $1,600.00 per person and $3,200.00 per group effective January 1, 2016. The fact that you did not understand that the plan you enrolled you and your spouse in as a couple meant a group deductible of $3,200.00 would be applied to you both does not mean that NYSOH misrepresented information to you when selecting your health plan.

The plan pages on the NYSOH webpage per your exhibits showed a maximum annual deductible for a group plan. You in fact enrolled as a couple, so together, your annual deductible would be up to $4,000.00. After the applicable cost-sharing reductions was applied to your plan, your annual deductible came to $3,200.00. Although it is true you as an individual may have incurred the amount attributable to an individual only plan, you had not yet reached the amount required for the group.

Since the record does not indicate that NYSOH, by action or inaction, made an error or misrepresented information, a special enrollment period cannot be granted.

The credible evidence of record indicates that, since the open enrollment period closed on January 31, 2016, no other triggering events have occurred that would qualify you for a special enrollment period.

Therefore, NYSOH’s March 9, 2016 eligibility determination that you do not qualify to select a health plan outside of the open enrollment period for 2016 was proper and is AFFIRMED.

The second issue under review is whether NYSOH provided you a timely notice that your daughter [redacted] was no longer eligible to remain enrolled in her Medicaid Managed Care plan due to having third party health insurance effective March 31, 2016.

Under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.” The individual will remain enrolled in their Medicaid Managed Care plan for 12 months unless a qualifying event occurs that would disenroll them. Such an event includes if that individual enrolls in third party health insurance.

Credible evidence confirms that your daughter was eligible for Medicaid effective August 1, 2015, and enrolled in a Medicaid Managed Care plan starting October 1, 2015.

You testified that your daughter had third party health insurance through her school for a travel abroad program for the month of March, 2016, which you informed NYSOH of on March 8, 2016. The record reflects a NYSOH agent deleted your daughter’s enrollment in her Medicaid Managed Care plan on March 8, 2016. A disenrollment notice was then issued on March 9, 2016, stating your daughter’s enrollment would end effective March 31, 2016.

You further explained that is was your belief that her disenrollment would be only temporary, and she would be re-enrolled in her Medicaid Managed Care plan after returning from her trip at the end of March, 2016.

Your daughter remained eligible for and enrolled in Medicaid Fee-For-Service during the month of April, 2016. She then incurred medical costs during that month which were not covered by her physician, as he does not accept Medicaid-Fee-For-Service.

You then submitted documentation as proof that your daughter’s third party health insurance had ended April 3, 2016. The documentation you provided was in the form of a one-page letter dated March 16, 2016 from her school and uploaded on June 17, 2016, to your NYSOH account (See Appellant’s Exhibit C, [redacted]. The documentation was used in your June 23, 2016, application and she was found eligible to enroll in the Essential Plan along with your household effective August 1, 2016.

Because you had not reapplied and enrolled your daughter in a Medicaid Managed Care plan after her disenrollment effective March 31, 2016, NYSOH was under no obligation to re-enroll her without evidence of the termination of her third party health insurance. This was accomplished after receiving your updated

letter, and updated application on June 23, 2016, at which time an eligibility determination was made in regards to her new eligibility for enrollment.

Therefore the March 9, 2016, disenrollment notice terminating your daughter's enrollment in her Medicaid Managed Care plan effective March 31, 2016 due to no longer being eligible to remain enrolled was proper and is AFFIRMED.

Decision

The March 9, 2016, eligibility determination is AFFIRMED.

The March 9, 2016, disenrollment notice is AFFIRMED.

Effective Date of this Decision: October 4, 2016

How this Decision Affects Your Eligibility

You and your spouse do not qualify for a special enrollment period at this time.

This decision does not change your daughter's [redacted] eligibility.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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:

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- By fax: 1-855-900-5557

Summary

The March 9, 2016, eligibility determination is AFFIRMED.

The March 9, 2016, disenrollment notice is AFFIRMED.

You and your spouse do not qualify for a special enrollment period at this time.

This decision does not change your daughter's eligibility.

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).