nystateofhealth
The Official Health Plan Marketplace

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

Notice of Decision

Decision Date: DATE

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014358

[redacted]

Dear [redacted]

On March 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 28, 2016 disenrollment notice, and September 27, 2016 enrollment confirmation 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: March 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014358

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that your enrollment in your Essential Plan coverage ended, effective September 30, 2016?
>
> Did NYSOH properly determine that your enrollment in your Essential Plan coverage resumed on November 1, 2016?

Procedural History

On December 20, 2015, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, effective January 1, 2016. You were subsequently enrolled into an Essential Plan.

On September 26, 2016, you twice updated your application for financial assistance with health insurance through NYSOH. After the first application, you were preliminarily found eligible for Medicaid; however, this preliminary eligibility was changed to the Essential Plan after the second.

On September 27, 2016, NYSOH issued a disenrollment notice stating that your Medicaid fee-for-service coverage through NYSOH would end effective October 31, 2016.

Also on September 27, 2016, NYSOH issued a notice stating that you were enrolled in an Essential Plan, effective November 1, 2016.

On September 28, 2016, NYSOH issued a notice of disenrollment, stating that your previous enrollment in your Essential Plan coverage was terminated effective September 30, 2016 because you were no longer eligible to remain enrolled in your current health insurance.

On December 27, 2016, you spoke to NYSOH's Account Review Unit and appealed the fact that you were disenrolled from your Essential Plan coverage as of September 30, 2016, and that your re-enrollment into Essential Plan coverage did not begin until November 1, 2016.

On March 9, 2017, 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 supports the following findings of fact:

1) You were determined eligible for the Essential Plan on December 20, 2015, effective January 1, 2016, and you enrolled into a plan that began coverage on January 1, 2016.

2) Your NYSOH account reflects that, on September 26, 2016, you updated your NYOH application online. In that application, you indicated that you were pregnant, and that you were expecting one child on [redacted]

3) Your NYSOH account reflects that, later in the day on September 26, 2016, you updated your NYSOH application by phone with a NYSOH representative. In that application, it was indicated that you were not pregnant.

4) The expected annual household income listed in both September 26, 2016 application updates was $20,182.25, and you testified that this amount was correct.

5) You testified that you plan to file your tax return with a tax filing status of single, and that you will claim no dependents on that tax return.

6) You testified that you logged into your NYSOH account late on September 26, 2016 because you had just found out that you were pregnant, and wanted to find out what you needed to do to update your coverage for the following year.

7) You testified that you were not trying to change your coverage on September 26, 2016; instead, you were trying to do research about coverage and premium options for the following year.

8) You testified that you received an email stating that you were now eligible for Medicaid and that your Essential Plan coverage was being cancelled, so you called NYSOH back later in the day on September 26, 2016.

9) You testified that you spoke to a couple of different NYSOH representatives when you called on September 26, 2016.

10) You testified that the second representative you spoke with informed you that you were supposed to report to NYSOH if you were pregnant, and that you told the person that was fine, but you did not want to lose coverage.

11) You testified that the representative who assisted you in updating your application did not state that they were going to change your application to say that you were not pregnant.

12) You testified that you did not know that your re-enrollment into your Essential Plan coverage would not start until November 1, 2016.

13) You testified that you had a [redacted], and the doctors you were seeing did not accept Medicaid.

14) You testified that you saw these doctors in the month of October 2016, and that you were not aware that your Essential Plan coverage had not started yet.

15) You testified that you have an unpaid medical bill from these doctors from the month of October 2016.

16) You testified that you are looking for your Essential Plan coverage to be backdated to October 1, 2016.

17) You testified that your pregnancy did not go to term.

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

Applicable Law and Regulations

Household Composition

For purposes of advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR), the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

For purposes of Medicaid eligibility, however, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Medicaid FPL for Pregnant Women

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the federal poverty level (FPL) for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

Medicaid

Medicaid can be provided through NYSOH 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 FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL “for the applicable budget period used to determine an individual's eligibility” (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is $16,020.00 for a two-person household (81 Federal Register 4036).

A pregnant woman who is determined to be eligible for Medicaid on the basis of expanded income eligibility will continue to be eligible for Medicaid services through the end of the month in which the 60th day following the end of the pregnancy occurs, regardless of any change in income (NY Social Services Law § 366(4)(b)(1)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable FPL or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2015 FPL, which is $11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your enrollment in your Essential Plan coverage should end, effective September 30, 2016.

On September 26, 2016, you updated your application for financial assistance with health insurance coverage. In that application, you indicated that your expected annual household income was $20,182.25, and that you were pregnant and expecting one child on May 3, 2017.

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver. Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size.

Based on the changes that you made to the application on September 26, 2016, your eligibility was based on a household of two (as you indicated you were expecting one child), with an expected annual income of $20,182.25. Since a household income of $20,182.25 is 125.98% of the 2016 FPL for a two-person household, you were found eligible for Medicaid.

You testified that you went into your account on September 26, 2016 to explore your options for coverage in 2017, given that you were pregnant. You testified that you were not trying to change your coverage, and did not want to lose your eligibility for the Essential Plan, as you had a [redacted], and the doctors you were seeing did not accept Medicaid.

You testified that you contacted NYSOH to explain to them that you needed to be put back into Medicaid. The record reflects that a NYSOH representative altered your application to state that you were not pregnant, which resulted in your eligibility reverting back to the Essential Plan.

You credibly testified that you were not aware that the NYSOH representative marked that you were not pregnant on your application. Nevertheless, the NYSOH representative's actions in altering your application to reflect incorrect information – namely that you were not pregnant – caused your eligibility to change to the Essential Plan, when it should have been Medicaid. An individual who is applying for financial assistance has an obligation to report accurate information, and does not have an option to choose the level of financial assistance he or she is eligible for.

Therefore, since you were eligible for Medicaid as of your September 26, 2016 application update, based on your income, household size, and pregnancy, your enrollment in your Essential Plan coverage was properly terminated, and the September 28, 2016 disenrollment notice is AFFIRMED.

The second issue under review is whether your re-enrollment into your Essential Plan coverage properly began on November 1, 2016.

As discussed above, you were eligible for Medicaid as of your September 26, 2016 application. Additionally, since your re-enrollment into the Essential Plan was a result of a NYSOH representative's actions in providing inaccurate information in your application, it was not correct.

Therefore, NYSOH's September 27, 2016 enrollment confirmation notice, confirming your enrollment in an Essential Plan, with a start date of November 1, 2016, is RESCINDED, as you were not eligible for Essential Plan coverage.

Your case is RETURNED to NYSOH to reinstate you in your Medicaid fee-for-service coverage, effective October 1, 2016.

Since you were eligible for Medicaid, you should have been able to select a Medicaid Managed Care plan, as of your September 26, 2016 application. Your case is RETURNED to NYSOH to facilitate your enrollment in a Medicaid Managed Care plan of your choosing, with a plan start date of November 1, 2016.

You testified at the hearing that your pregnancy did not go to term. Medicaid eligibility based on pregnancy is effective until the end of the month in which the 60th day following the end of the pregnancy occurs. Therefore, since you testified that you are no longer pregnant, your case is also RETURNED to NYSOH to assist you in updating your application so that your current eligibility for financial assistance can be redetermined.

Decision

The September 28, 2016 disenrollment notice is AFFIRMED.

The September 27, 2016 enrollment confirmation notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in fee-for-service Medicaid coverage, effective October 1, 2016.

Your case is RETURNED to NYSOH to facilitate your enrollment in a Medicaid Managed Care plan of your choosing, with an enrollment start date of November 1, 2016.

Your case is RETURNED to NYSOH to assist you in updating your application for financial assistance so that your current eligibility can be determined.

Effective Date of this Decision: March 29, 2017

How this Decision Affects Your Eligibility

You were eligible for Medicaid, effective October 1, 2016.

Your enrollment in your Essential Plan coverage properly terminated as of September 30, 2016.

You remained eligible for Medicaid as of November 1, 2016, and were not eligible for the Essential Plan.

Your case is being sent back to NYSOH to reinstate you in fee-for-service Medicaid as of October 1, 2016.

You should have had the opportunity to enroll in a Medicaid Managed Care plan, so your case is being sent back to NYSOH to assist you in doing that. Your enrollment in your Medicaid Managed Care plan will start on November 1, 2016.

Since you are no longer pregnant, your case is being sent back to NYSOH to assist you in updating your application for financial assistance so that your current eligibility can be redetermined.

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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The September 28, 2016 disenrollment notice is AFFIRMED.

The September 27, 2016 enrollment confirmation notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in fee-for-service Medicaid coverage, effective October 1, 2016.

Your case is RETURNED to NYSOH to facilitate your enrollment in a Medicaid Managed Care plan of your choosing, with an enrollment start date of November 1, 2016.

Your case is RETURNED to NYSOH to assist you in updating your application for financial assistance so that your current eligibility can be determined.

You were eligible for Medicaid, effective October 1, 2016.

Your enrollment in your Essential Plan coverage properly terminated as of September 30, 2016.

You remained eligible for Medicaid as of November 1, 2016, and were not eligible for the Essential Plan.

Your case is being sent back to NYSOH to reinstate you in fee-for-service Medicaid as of October 1, 2016.

You should have had the opportunity to enroll in a Medicaid Managed Care plan, so your case is being sent back to NYSOH to assist you in doing that. Your enrollment in your Medicaid Managed Care plan will start on November 1, 2016.

Since you are no longer pregnant, your case is being sent back to NYSOH to assist you in updating your application for financial assistance so that your current eligibility can be redetermined.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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।

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 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.

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).