



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

Notice of Decision

Decision Date: April 06, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014727

[REDACTED]

Dear [REDACTED],

On April 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 3, 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 NY State of Health 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: April 06, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000014727

[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, and your spouse's, enrollment in your Essential Plan coverage ended effective December 31, 2016?

Procedural History

On November 15, 2016, you applied for financial assistance with the cost of health insurance through NYSOH on behalf of yourself, your spouse, and your children. You also uploaded documentation to your NYSOH account that same day.

On November 16, 2016, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to enroll in the Essential Plan for a limited time, with a monthly premium of \$20.00 each, effective December 1, 2016. The notice further directed you to provide documentation confirming your income before February 13, 2017.

Also on November 16, 2016, NYSOH issued a notice confirming your enrollment in an Essential Plan, effective December 1, 2016.

On December 2, 2016, NYSOH updated your application for financial assistance.

On December 3, 2016, NYSOH issued a notice stating that your December 2, 2016 application had been reviewed, but that the information in your application

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did not match what NYSOH had received from state and federal data sources. The notice directed you to provide documentation of your household income by December 17, 2016.

That same day, NYSOH issued a disenrollment notice stating that your enrollment, and your spouse's enrollment, in your Essential Plan coverage was ending, effective December 31, 2016, because you were no longer eligible to enroll in the Essential Plan.

Also on December 3, 2016, NYSOH issued a notice stating that the documentation you had provided did not confirm the information in your application. The notice directed you to submit proof of income by December 17, 2016.

On December 13, 2016 and December 19, 2016, you uploaded documentation to your NYSOH account.

On December 29, 2016, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective February 1, 2017.

Also on December 29, 2016, NYSOH issued a notice of enrollment confirmation, confirming your enrollment, and your spouse's enrollment, in an Essential Plan, effective February 1, 2017.

On January 9, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your, and your spouse's, Essential Plan for the month of January 2017.

On April 3, 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 testified that you applied for financial assistance on November 15, 2016 by phone with a NYSOH representative.
- 2) Your NYSOH account reflects that you uploaded income documentation that same day, consisting of four consecutive weekly paystubs for yourself.

- 3) You also uploaded three paystubs for your spouse, dated September 29, 2016, September 30, 2016, and October 31, 2016 (Documents [REDACTED], [REDACTED], and [REDACTED]).
- 4) The October 31, 2016 paystub showed year-to-date gross income of \$22,645.00 (Document [REDACTED]).
- 5) You testified that you explained to the NYSOH representative who completed your application with you on November 15, 2016 that your spouse was paid inconsistently.
- 6) Your NYSOH account reflects that your application was updated by a NYSOH employee on December 2, 2016, who changed your application to show that your spouse had \$0.00 in income. Notes in your NYSOH account indicate that this change was made when a NYSOH employee determined that the income documentation you had submitted was not valid.
- 7) You testified that you received the notice dated December 3, 2016 stating that the income documentation you had provided was not sufficient, but that the notice did not tell you specifically what the problem was.
- 8) You testified that you uploaded another paystub for your spouse on December 13, 2016, and your NYSOH account reflects that a paystub dated December 7, 2016 was uploaded on that day (Document [REDACTED]).
- 9) You testified that you called NYSOH after you sent in the paystub on December 13, 2016 to find out whether everything was resolved, and that you were informed at that time that the NYSOH representative who completed your application with you on November 15, 2016 had entered income information showing that your spouse was paid semi-monthly.
- 10) You testified, and your NYSOH account confirms, that you then uploaded a letter from your spouse's employer on December 19, 2016 explaining that she has not been paid bi-monthly for the past three months, and that her pay fluctuates based on the hours she works (Document [REDACTED]).
- 11) You also submitted a record from her employer showing her pay dates and earnings for the period of September 29, 2016 through December 18, 2016 (Document [REDACTED]).

- 12) On December 28, 2016, NYSOH updated your application based on the information in the documentation you had submitted, and you and your spouse were found eligible for the Essential Plan as of February 1, 2017. You were both subsequently enrolled into an Essential Plan with a February 1, 2017 start date.
- 13) You testified that you are seeking to be reinstated in your Essential Plan coverage for the month of January 2017, as you had medical bills for yourself in that month.

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

Applicable Law and Regulations

Verification of Eligibility for the 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 federal poverty level (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).

NYSOH must verify the eligibility of an applicant for the Essential Plan consistent with the standards set in 45 CFR § 155.315 and § 155.320 (New York's Basic Health Plan Blueprint, pgs. 16-17, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>; 42 CFR § 600.345(a)(2)).

An applicant is required to attest to their household's projected annual income. (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request

additional information from the applicant in order to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your, and your spouse's, eligibility for, and enrollment in, the Essential Plan ended effective December 31, 2016.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to his or her household's projected annual income. For individuals seeking enrollment in the Essential Plan, NYSOH must request income data from federal data sources in order to verify an individual's income attestation.

If NYSOH cannot verify an individual's attestation, it must provide the individual with notice of the inconsistency and provide a period of 90 days from the date notice is received to resolve the inconsistency.

In the eligibility determination issued on November 16, 2016, you were advised that you and your spouse were eligible for the Essential Plan for a limited time, and that you needed to confirm your household's income before February 13, 2017.

The record reflects that you uploaded income documentation on November 15, 2016: the same day that you applied for financial assistance. This documentation consisted of four consecutive weekly paystubs for yourself, and three paystubs for your spouse.

A review of your NYSOH account shows that someone at NYSOH reviewed the income documentation that you provided on December 2, 2016, and determined that the documentation was not sufficient. This resulted in the issuance of a notice, dated December 3, 2016, informing you that the documentation you had submitted was insufficient, and that additional documentation was necessary.

Since the notice of November 16, 2016 informed you that you had until February 13, 2017 to submit income documentation, the NYSOH employee who reviewed

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your income documentation on December 2, 2016 should not have taken any further action. However, for reasons that are not apparent, the NYSOH employee updated your application for financial assistance on December 2, 2016, and indicated that your spouse had \$0.00 in expected annual income. This was done despite the fact that you had submitted paystubs showing that your spouse had already earned over \$22,000.00 in 2016.

The NYSOH employee's actions resulted in your entire household being placed in a "pending Medicaid" status, and caused you and your spouse to be disenrolled from your Essential Plan coverage. Therefore, it was NYSOH's actions on December 2, 2016 that caused there to be a gap in your, and your spouse's Essential Plan coverage in the month of January 2017.

For this reason, the December 3, 2016 disenrollment notice is RESCINDED, insofar as it ended your and your spouse's Essential Plan enrollment on December 31, 2016.

Your case is RETURNED to NYSOH to reinstate you and your spouse in your Essential Plan for the month of January 2017. You will be responsible for your premium payment for that month.

Decision

The December 3, 2016 disenrollment notice is RESCINDED, insofar as it stated that your, and your spouse's, enrollment in your Essential Plan ended on December 31, 2016.

Your case is RETURNED to NYSOH to reinstate you and your spouse in your Essential Plan for the month of January 2017, so that there is no gap in your coverage.

Effective Date of this Decision: April 06, 2017

How this Decision Affects Your Eligibility

NYSOH improperly disenrolled you and your spouse from your Essential Plan coverage in the month of January 2017.

Your case is being sent back to NYSOH to reinstate your, and your spouse's, Essential Plan coverage in the month of January 2017.

You are responsible for your Essential Plan premium payment for yourself and your spouse for the month of January 2017.

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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

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P.O. Box 11729
Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The December 3, 2016 disenrollment notice is RESCINDED, insofar as it stated that your, and your spouse's, enrollment in your Essential Plan ended on December 31, 2016.

Your case is RETURNED to NYSOH to reinstate you and your spouse in your Essential Plan for the month of January 2017, so that there is no gap in your coverage.

NYSOH improperly disenrolled you and your spouse from your Essential Plan coverage in the month of January 2017.

Your case is being sent back to NYSOH to reinstate your, and your spouse's, Essential Plan coverage in the month of January 2017.

You are responsible for your Essential Plan premium

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 bεtumi 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 איר געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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