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

Notice of Decision

Decision Date: May 04, 2017

NY State of Health Account ID: [redacted]

Appeal Identification Number: AP000000014833
AP000000013923

Dear [redacted],

On April 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 17, 2016 eligibility determination and disenrollment notices.

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 at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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
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Decision

Decision Date: May 04, 2017

NY State of Health Account ID:

Appeal Identification Number: AP000000014833
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Issues

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

> Did New York State of Health (NYSOH) properly end your child's Medicaid coverage effective October 31, 2016?
>
> Did NYSOH properly end your Essential Plan coverage effective October 31, 2016?
>
> Did NYSOH properly end your spouse's financial assistance effective October 31, 2016?

Procedural History

(inactive account)

On November 23, 2015, NYSOH issued an eligibility determination stating that your spouse was conditionally eligible to receive up to $285.00 of advance premium tax credit (APTC) and cost-sharing reductions (CSR), and you were eligible to enroll in the Essential Plan for a limited time, both effective as of January 1, 2016. The notice directed each of you to submit additional income documentation before February 20, 2016, to confirm your eligibility.

Also on November 23, 2015, NYSOH issued an enrollment notice confirming that your spouse was enrolled in a qualified health plan (QHP) with a premium of

$89.10, and you were enrolled in an Essential Plan. The notice stated that each plan had a plan enrollment start date of January 1, 2016.

On January 22, 2016, your NYSOH account was updated.

On January 23, 2016, NYSOH issued an eligibility determination notice stating that: (1) your spouse was eligible to receive up to $285.00 of APTC and CSR effective as of March 1, 2016; (2) you were eligible to enroll in the Essential Plan effective as of March 1, 2016, and (3) your child was eligible for Medicaid effective as of January 1, 2016.

On July 16, 2016, NYSOH issued a disenrollment notice stating that you requested to end your insurance coverage with UnitedHealthcare Community Plan on July 15, 2016, and will no longer have that coverage effective July 31, 2016.

Also on July 16, 2016, NYSOH issued an enrollment notice confirming, (1) your spouse was enrolled in a QHP with an enrollment start date of January 1, 2016; (2) you were enrolled in an Essential Plan, through Empire Blue Cross Blue Shield, with an enrollment start date of August 1, 2016, and (3) your child still needed to pick a health plan.

On September 16, 2016, NYSOH issued a renewal notice stating that it was time to renew your family's health insurance. That notice stated that based on the information from federal and state sources, NYSOH could not make a decision about whether your family qualified for financial help paying for your health coverage, and that you needed to update your account by October 15, 2016 or you might lose the financial assistance your family was receiving.

On October 16, 2016, your NYSOH account was updated systemically.

On October 17, 2016, NYSOH issued four notices:

(1) An eligibility determination notice stating that you and your spouse were newly eligible to purchase a QHP at full cost effective as of November 1, 2016, because you did not complete your renewal in the required timeframe;
(2) An eligibility determination notice stating that your child was not eligible for financial assistance or to purchase a QHP at full cost effective November 1, 2016, because you did not complete the renewal within the required timeframe;
(3) A disenrollment notice stating that your Essential Plan and your child's Medicaid fee-for-service would be discontinued as of October 31, 2016; and
(4) An enrollment notice stating that your spouse was enrolled in a QHP, with a monthly premium of $374.10;

(active account)

On November 17, 2016, a financial assistance application was submitted for your family.

On November 18, 2016, NYSOH issued an eligibility determination notice stating that: (1) you were eligible to enroll in the Essential Plan for a limited time; (2) your spouse was eligible for up to $340.00 monthly of APTC and CSR; and (3) your child was eligible for Child Health Plus for a limited time. Each eligibility was effective as of January 1, 2017, and were directed to submit additional income documentation to confirm your family's eligibility.

Also on November 18, 2016, NYSOH issued an enrollment notice confirming: (1) you were enrolled in an Essential Plan; your spouse was enrolled in a QHP, with a monthly premium of $133.97, and your child was enrolled in Child Health Plus. Each enrollment had a plan enrollment start date of January 1, 2017.

On December 9, 2016 and January 12, 2017 , you spoke with NYSOH's Account Review Unit and requested an appeal insofar as the termination of your, your spouse, and child's financial assistance through NYSOH.

On April 19, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during that 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 you are appealing the fact that: (1) your child's Medicaid fee-for-service ended on October 31, 2016; your Essential Plan coverage ended on October 31, 2016, and (3) your spouse's APTC ended on October 31, 2016.

2. According to your NYSOH account, your seventeen-year-old child was found eligible for Medicaid effective January 1, 2016.

3. According to your NYSOH account, you were found eligible for and enrolled in an Essential Plan effective January 1, 2016.

4. According to your NYSOH account, your spouse was determined eligible for $285.00 monthly of APTC and CSR effective January 1, 2016.

5. According to your NYSOH [redacted] account: your Essential Plan, your child's Medicaid coverage, and your spouse's APTC and CSR ended October 31, 2016.

6. You testified that you never received a disenrollment notice from NYSOH stating that any of your family's enrollments would be terminated.

7. According to your NYSOH accounts [redacted] you receive notices from NYSOH via regular mail.

8. You testified that you first discovered that your child's health coverage had been discontinued when you were contacted by your child's doctor in November 2016.

9. You testified that you contacted NYSOH and the representatives were unable to access account [redacted]. Therefore, account [redacted] was created to enroll your family in health coverage for January 1, 2017.

10. You testified that you want: (1) to be enrolled in an Essential Plan for November and December 2016: (2) your child to be enrolled in Medicaid coverage for November and December 2016, and (3) your spouse's APTC reinstated for November 2016.

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

Applicable Law and Regulations

Medicaid:

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York Department of Health Administrative Directive 13 OHIP ADM-03).

Continuous Coverage:

A child under the age of nineteen who is determined eligible for medical assistance shall remain eligible for such assistance until the last day of the month which is twelve months following the determination or redetermination of eligibility for such assistance (N.Y. Soc. Serv. Law § 366(4)(b)(3)(i)).

Essential Plan - Renewal

New York State has also elected to redetermine Essential Plan enrollees every 12 months from the effective date of eligibility as long as enrollees are under age 65, are not enrolled in minimum essential coverage, and remain state residents.

An individual enrolled in the Essential Plan shall have his or her coverage continued until the end of the 12-month period, provided he or she does not lose eligibility by reason of citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage, failure to make the applicable premium payment, or changes in circumstances (42 CFR § 600.340(f); NY Social Services Law § 369-gg(3) and (4)(d)). Enrollees are required to report changes in circumstances within 30 days, which NYSOH will assess and act upon accordingly (New York's Basic Health Plan Blueprint, p. 17, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

QHP Eligibility - Redetermination During a Benefit Year:

NYSOH must redetermine the eligibility of an enrollee in a qualified health plan during the benefit year if it receives and verifies new information by an enrollee or identifies updated information through federal or state data sources (45 CFR § 155.330(a)).

If NYSOH identifies updated information based on data sources, regarding income, family size, or family composition, with the exception of information regarding death, the NYSOH must notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination (45 CFR §§ 155.330(e)(2)(ii), 155.330(e)(2)(i)(A)) . NYSOH must allow an enrollee 30 days from the date of the notice to notify NYSOH that such information is inaccurate (45 CFR § 155.330(e)(2)(i)(B)). If the enrollee does not respond to the notice within the 30-day period, the enrollee's existing eligibility determination must be maintained, without considering the updated information (45 CFR § 155.330(e)(2)(ii)(C)).

Legal Analysis

The first issue under review is whether NYSOH properly ended your child's Medicaid coverage effective October 31, 2016.

On January 23, 2016, NYSOH issued an eligibility determination notice stating that your child was eligible for Medicaid effective as of January 1, 2016.

Generally, once individuals are determined eligible for Medicaid, they are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates made to their NYSOH account. This twelve-

month period is based on the start date of the original Medicaid eligibility determination.

When your child's Medicaid coverage was discontinued on October 31, 2016, the twelve-month period of Medicaid eligibility that began on January 1, 2016, had not expired. Furthermore, the record does not contain any evidence that your child's eligibility should have been discontinued before the end of their twelve-months of eligibility. Therefore, your child's Medicaid coverage should not have ended effective October 31, 2016.

The October 17, 2016 disenrollment notice is RESCINDED.

Your child's case is RETURNED to NYSOH to reinstate their Medicaid coverage for the months of November and December 2016.

The second issue under review is whether NYSOH properly disenrolled you from your Essential Plan coverage effective October 31, 2016.

On November 23, 2015, you submitted an application for financial assistance. As a result of this application, you were found eligible for the Essential Plan and enrolled in a health effective as of January 1, 2016.

On September 16, 2016, NYSOH issued a renewal notice stating that based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by October 15, 2016, or you might lose the financial assistance you were receiving.

On October 17, 2016 NYSOH issued an eligibility determination notice, in relevant part, that you were determined eligible to enroll in a QHP at full cost and not eligible for the Essential Plan effective November 1, 2016, because you did not respond to the renewal notice.

New York State has elected to redetermine Essential Plan enrollees every 12 months from the effective date of eligibility as long as enrollees are under age 65, are not enrolled in minimum essential coverage, and are state residents. An individual enrolled in the Essential Plan shall have his or her coverage continued until the end of the 12-month period, provided he or she does not lose eligibility by reason of citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage, failure to make the applicable premium payment, or changes in circumstances.

Since you were found eligible for and enrolled in the Essential Plan as of January 1, 2016, your coverage should have continued for 12 months; that is, until December 31, 2016, barring any of the disqualifying events stated above.

In the present case, NYSOH issued an eligibility determination notice stating that you were no longer eligible for financial assistance because you did not respond to the renewal notice. Therefore, the record does not contain one of the disqualifying events that would have ended your coverage in the Essential Plan prior to the end of the 12-month period.

NYSOH improperly redetermined your eligibility prior to the expiration of the 12-month period of eligibility. Therefore, the October 17, 2016, eligibility determination is RESCINDED.

The third issue under review is whether NYSOH improperly ended your spouse's financial assistance as of October 31, 2016.

On November 23, 2015, NYSOH issued an eligibility determination and enrollment notices stating that your spouse was conditionally eligible to receive up to $285.00 of advance premium tax credit (APTC) and cost-sharing reductions and enrolled in a QHP with an enrollment start date of January 1, 2016.

NYSOH must redetermine the eligibility of an enrollee in a QHP during the benefit year if it receives and verifies new information by an enrollee or identifies updated information through federal or state data sources.

If NYSOH identifies updated information based on data sources, regarding income, family size, or family composition, NYSOH must issue a notice that contains the enrollee's projected eligibility determination.

On September 16, 2016, NYSOH issued a renewal notice stating that it was time for your spouse to renew their coverage. That notice stated that based on the information from federal and state sources, NYSOH could not make a decision about whether your spouse qualified for financial help paying for your health coverage, and that you needed to update your account by October 15, 2016 or you might lose the financial assistance your family was receiving.

NYSOH must allow an enrollee 30 days from the date of the notice to notify NYSOH that such information is inaccurate. If the enrollee does not respond to the notice within the 30-day period, the enrollee's existing eligibility determination must be maintained, without considering the updated information.

NYSOH did not receive any updated information from your spouse by October 15, 2016. Therefore, NYSOH was required to maintain your spouse's previous eligibility determination, without considering the information in the September 16, 2016 notice.

On October 17, 2016, NYSOH improperly issued eligibility determination and enrollment notices reflecting that your spouse was newly eligible to purchase a

QHP at full cost effective as of November 1, 2016, because a renewal was not completed in the required timeframe.

Therefore, the October 17, 2016 eligibility determination notice is RESCINDED.

Your spouse's case is RETURNED to NYSOH reinstate their APTC and CSR for the month of November 2016.

Decision

The October 17, 2016 eligibility determination notice stating that you and your spouse were newly eligible to purchase a QHP at full cost effective as of November 1, 2016 is RESCINDED.

The October 17, 2016 eligibility determination notice stating that your child was not eligible for financial assistance or to purchase a QHP at full cost effective November 1, 2016 is RESCINDED.

The October 17, 2016 disenrollment notice stating that your Essential Plan and your child's Medicaid fee-for-service would be discontinued as of October 31, 2016 is RESCINDED.

Your child's case is RETURNED to NYSOH to reinstate their Medicaid coverage for the months of November and December 2016.

Your case is RETURNED to NYSOH to reinstate your Essential Plan coverage for the months of November and December 2016.

Your spouse's case is RETURNED to NYSOH reinstate their APTC and CSR for the month of November 2016.

Effective Date of this Decision: May 04, 2017

How this Decision Affects Your Eligibility

You, your spouse, and child's financial assistance was improperly discontinued effective October 31, 2016.

Your child's case is returned to NYSOH to reinstate their Medicaid coverage for the months of November and December 2016.

Your case is returned to NYSOH to reinstate your Essential Plan coverage for the months of November and December 2016.

Your spouse's case is returned to NYSOH to reinstate their APTC and CSR for the month of November 2016.

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 October 17, 2016 eligibility determination notice stating that you and your spouse were newly eligible to purchase a QHP at full cost effective as of November 1, 2016 is RESCINDED.

The October 17, 2016 eligibility determination notice stating that your child was not eligible for financial assistance or to purchase a QHP at full cost effective November 1, 2016 is RESCINDED.

The October 17, 2016 disenrollment notice stating that your Essential Plan and your child's Medicaid fee-for-service would be discontinued as of October 31, 2016 is RESCINDED.

You, your spouse, and child's financial assistance was improperly discontinued effective October 31, 2016.

Your child's case is returned to NYSOH to reinstate their Medicaid coverage from November 1, 2016 through December 31, 2016.

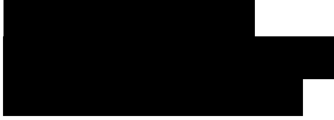
Your case is returned to NYSOH to reinstate your Essential Plan coverage for the months of November and December 2016.

Your spouse's case is returned to NYSOH to reinstate their APTC and CSR for the month of November 2016.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

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).

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.

(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.

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).