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

Notice of Decision

Decision Date: June 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016004

[redacted]

Dear [redacted]

On May 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 16, 2016 eligibility determination notice, and November 22, 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: June 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016004

[redacted]

Issue

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

> Did NY State of Health properly determine you were no longer eligible to remain enrolled in your Essential Plan effective November 30, 2016?

Procedural History

On December 12, 2015, NYSOH issued an eligibility determination notice was issued stating you were eligible for the Essential Plan starting January 1, 2016. You subsequently enrolled in an Essential Plan with a start date of January 1, 2016.

On October 13, 2016, NYSOH issued a renewal notice stating based on information from federal and state data sources, a decision could not be made about whether or not you qualify for financial assistance. The renewal notice asked you to update the information in your account by December 15, 2016. If you missed this deadline, the financial assistance you were getting could end.

On November 15, 2016, NYSOH received your updated application for financial assistance.

On November 16, 2016, NYSOH issued an eligibility determination notice based on that last application stating you were eligible for a tax credit up to $221.00 per month as well as cost sharing reductions if you enrolled in a Silver level qualified health plan effective December 1, 2016. The notice further stated you no longer

qualified for the Essential Plan as of November 30, 2016. The determination was based on your attested household income of $25,572.48.

On November 22, 2016, a disenrollment notice was issued stating your Essential Plan coverage would end November 30, 2016. The notice stated this was because you were no longer eligible to enroll in the Essential Plan.

On December 8, 2016, an eligibility determination notice was issued based on your December 7, 2016 application stating you were eligible for the Essential Plan starting January 1, 2017.

Also on December 8, 2016, NYSOH issued a notice of enrollment based on your plan selection on December 7, 2016, stating your enrollment in the Essential Plan was effective January 1, 2017.

On January 18, 2017, a notice was issued based on your January 17, 2017 application stating you were eligible for the Essential Plan effective February 1, 2017.

Also on January 18, 2017, NYSOH issued a notice of enrollment based on your plan selection on January 17, 2017, stating your enrollment in the Essential Plan was effective January 1, 2017.

Also on January 18, 2017, a notice was issued stating your request for help with paying medical bills for December 1, 2016 through December 31, 2016 was denied because the program you were eligible for cannot pay for any care you received in the past.

On February 21, 2017, you spoke to NYSOH's Account Review Unit and appealed the denial of retro Medicaid, and the start date of your Essential Plan.

On May 26, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open 15 days to provide proof of your Social Security Disability and Pension fund disbursements.

On May 26, 2017, you uploaded copies of your Social Security Disability disbursements and Pension fund disbursements and have been incorporated into the record as (Appellant's Exhibit 1 & 2).

Findings of Fact

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

1) You submitted an application to NYSOH for financial assistance on November 15, 2016.

2) On November 15, 2016, you submitted an application to NYSOH with the aid of a NYSOH representative.

3) On December 7, 2016, you submitted an updated application to NYSOH.

4) You testified, and the record reflects, that you reenrolled in an Essential Plan on December 7, 2016.

5) You testified that you wanted your enrollment in an Essential Plan to begin on December 1, 2016 because you incurred medical bills in the month of December.

6) You testified that you expect to file your 2017 taxes with a tax filing status of single You will claim no dependents on that tax return.

7) You are seeking insurance for yourself.

8) The application that was submitted on November 15, 2016, which requested financial assistance, listed annual household income of $25,572.48, consisting of income you receive from Social Security Disability and Pension disbursements.

9) The application submitted on November 15, 2016 listed your income from your pension disbursement twice once as $509.82, and again in the amount of $529.82.

10) You provided documentation on May 26, 2017, that your monthly income you receive $529.00 per month in pension disbursements. See Appellant's Exhibit 1, [redacted].

11) You receive a gross of $529.82 per month in pension disbursements, which equates to a net payment of $509.82 after tax. See [redacted].

12) A review of the call made to NYSOH on November 15, 2016, shows you spoke with a NYSOH representative for the purpose of updating your application for 2017. However, the NYSOH representative submitted your application for December 1, 2016. You told the NYSOH representative you receive monthly income from your Social Security Disability and one pension payment. You were then told you now qualified for APTC. You stated you would like to keep the coverage the way it was and asked the representative if your plan would remain the same. He said it would.

13) You provided documentation on May 26, 2017 that you receive $1,094.00 in Social Security Disability payments. See Appellant's Exhibit 2, [redacted]

14) Your application states that you live in Chautauqua County.

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

Applicable Law and Regulations

Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Essential Plan: Renewal

New York State has elected to adopt the Medicaid policy regarding continuous enrollment throughout the year (42 CFR § 600.320(d); New York's Basic Health Plan Blueprint, pp. 8 and 16, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

This means that an individual may apply and enroll for coverage at any point in time throughout the year, including outside the open enrollment period and without needing a special enrollment period (NY Social Services Law § 369-gg(4)(d)).

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).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible for the Essential Plan, effective November 30, 2016.

On December 12, 2015, you were found eligible for the Essential Plan as of January 1, 2016, and you were enrolled into a plan.

On October 13, 2016, NYSOH issued a renewal notice stating based on information from federal and state data sources, a decision could not be made about whether or not you qualify for financial assistance. The renewal notice asked you to update the information in your account by December 15, 2016. If you missed this deadline, the financial assistance you were getting could end.

On November 15, 2016, you updated your NYSOH application with the aid of a NYSOH representative. That application which requested financial assistance, listed income you receive monthly from Social Security Disability and two pension disbursements. A review of the call made to NYSOH on November 15, 2016, shows you had called in to update your application for 2017 in response to the renewal notice you received. You told the NYSOH representative you receive monthly income from Social Security Disability and one pension payment.

However, the NYSOH representative updated your application to state that you receive a Social Security Monthly Disability payment of $1,094.00 and income from your pension disbursement twice a month, once at $509.82, and again in the amount of $529.82, leading to an annual household income of $25,572.48. Further, the representative indicated on this application that you were seeking financial assistance for 2016, not 2017

As a result, you were found eligible for APTC and cost-sharing reductions as of December 1, 2016. Since you were now no longer eligible for the Essential Plan, you were disenrolled from your Essential Plan effective November 30, 2016.

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, 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.

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.

Had the NYSOH representative correctly submitted your application for the 2017 coverage year, you would have continued to be enrolled in your Essential Plan for the remainder of 2016. Furthermore, on May 26, 2017 you provided documentation showing that you only receive one monthly disbursement from your pension in a gross amount of $529.00 disbursements and $1,094.00 in Social Security Disability payments.

Since the NYSOH representative incorrectly updated your application for the 2016 coverage year and included the incorrect income, the November 16, 2016 eligibility determination notice is RESCINDED.

The November 22, 2016 disenrollment notice was therefore improper since you were still eligible for the Essential Plan effective December 1, 2016, and is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Essential Plan for the month of December, 2016.

You will be responsible for any premium payment due to your health plan for that month.

Decision

The November 16, 2016 eligibility determination notice is RESCINDED.

The November 22, 2016 disenrollment notice terminating your enrollment in the Essential Plan effective December 1, 2016 is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Essential Plan for the month of December, 2016.

Effective Date of this Decision: June 30, 2017

How this Decision Affects Your Eligibility

You were eligible for the Essential Plan effective December 1, 2016.

You should not have been disenrolled from the Essential Plan effective November 30, 2016.

Your case is being returned to NYSOH to reinstate you in the Essential Plan for the month of December, 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

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).

- 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 November 16, 2016 eligibility determination is RESCINDED.

The November 22, 2016 disenrollment notice terminating your enrollment in the Essential Plan effective December 1, 2016 is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your Essential Plan for the month of December, 2016.

You were eligible for the Essential Plan effective December 1, 2016.

You should not have been disenrolled from the Essential Plan effective November 30, 2016.

Your case is being returned to NYSOH to reinstate you in the Essential Plan for the month of December, 2016.

Legal Authority

We are issuing this determination in accordance with 45 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).

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)

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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।

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 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 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.

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