



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

## Notice of Decision

Decision Date: July 13, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016867

[REDACTED]

Dear [REDACTED]

On June 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 11, 2017 eligibility determination 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: July 13, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016867

[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 you and your spouse's eligibility for financial assistance and enrollment in a qualified health ended effective January 31, 2017?

## Procedural History

On December 15, 2016, NYSOH received your and your spouse's application for financial assistance.

On December 16, 2016, NYSOH issued a notice of eligibility determination notice based on your last application, stating you and your spouse were conditionally eligible to receive advance payment of the premium tax credit up to \$366.00 per month, effective January 1, 2017. The notice further directed you to provide documentation confirming your immigration status before January 4, 2017, or your eligibility for coverage or financial assistance might end.

On December 16, 2016, NYSOH issued a notice confirming your and your spouse's enrollment in silver level qualified health plan, effective January 1, 2017.

No immigration documentation was received by NYSOH before January 4, 2017.

On January 11, 2017, NYSOH issued an eligibility redetermination notice stating that you and your spouse were not eligible for Medicaid, Child Health Plus, or 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).

receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a qualified health plan at full cost because you had not confirmed your immigration status within the required timeframe. Your eligibility for coverage ended effective February 1, 2017.

Also on January 11, 2017, NYSOH issued a cancellation notice stating your and your spouse's enrollment in your silver level qualified health plan would be terminated effective, January 31, 2017. The notice stated this was because you were no longer eligible to enroll in health insurance through NYSOH.

On February 9, 2017, NYSOH received your and your spouse's application for financial assistance and immigration documentation.

On February 10, 2017, NYSOH issued an eligibility determination notice stating you and your spouse may be eligible to enroll in coverage if you qualified for a special enrollment period. The notice stated you both qualified for advance payments of the premium tax credit up to \$298.00 per month for a limited time, effective March 1, 2017. The notice stated you needed to provide proof of your immigration status by May 10, 2017.

On March 15, 2017, you spoke to NYSOH's Account Review Unit and appealed January 11, 2017, eligibility determination insofar as it ended your financial assistance eligibility and enrollment in a qualified health plan on January 31, 2017.

On April 10, 2017, your immigration documentation was determined valid by a NYSOH representative.

On June 6, 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 for you provide copies of your newly issued Employment Authorization Cards. You provided documentation to your NYSOH account on June 19, 2017 and have been incorporated into the record. The record is now closed.

## **Findings of Fact**

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

- 1) You are seeking insurance for yourself and your spouse.
- 2) You initially applied for insurance with NYSOH on December 15, 2016.
- 3) You enrolled yourself and your spouse into a silver level qualified health plan effective January 1, 2017.

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).

- 4) You testified, and the record reflects, that you receive all of your notices from NYSOH by electronic mail.
- 5) You testified that you did not receive any electronic alerts notifying you of any notice in your NYSOH account stating that your eligibility was only conditional and that you needed to provide documentation of your and your spouse's immigration status by January 4, 2017.
- 6) You testified that you did not know that you needed to submit documentation of your and your spouse's immigration status and had been disenrolled from your health plan at the end of January, 2017, until you went to a doctor appointment in February, 2017.
- 7) The record reflects that on February 9, 2017, NYSOH received documentation of your immigration status in the form of an I-797 USCIS Notice of Action.
- 8) The immigration documentation you provided on February 9, 2017, was reviewed and determined valid by a NYSOH representative on April 10, 2017.
- 9) You testified you had been in the process of applying for valid employment authorization cards for yourself and your spouse during your application in December, 2016, and received the cards in February, 2017.
- 10) You provided copies of your and your spouse's employment authorization cards with an issue date of [REDACTED].

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

## **Applicable Law and Regulations**

### Citizenship and Immigration Status

To enroll in a qualified health plan through NYSOH, an applicant must be a citizen or national of the United States, or a non-citizen who is lawfully present in the United States and reasonably expects to become a citizen or remain a lawfully present noncitizen for the entire period for which enrollment is being sought (45 CFR § 155.305(a)(1)).

NYSOH must verify or obtain information in order to determine that an applicant is eligible for enrollment in a qualified health plan, including the certification of citizenship, status as a national, or lawful presence (45 CFR § 155.315(a), (c)).

If an applicant attests to citizenship, status as a national, or lawful presence, and NYSOH is unable to verify such attestation, NYSOH must provide the applicant with notice of the inconsistency. NYSOH must then provide the applicant with 90 days to provide satisfactory documentary evidence, from the date the notice of inconsistency is received by the applicant. Notice is considered received 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5-day period. (45 CFR § 155.315(c)(3), (f)(2)(i)).

If NYSOH remains unable to verify the citizenship attestation after the 90-day period ends, it must determine the applicant's eligibility based on the information available (45 CFR § 155.315(f)(5)).

### Electronic Notices

Applicants may choose to receive notices and information from NYSOH by either electronic or regular mail. If the applicant elects to receive electronic notices, NYSOH must send an email or other electronic communication alerting the individual that a notice has been posted to the applicant's account (45 CFR §155.230(d); 42 CFR §435.918(b)(4)).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that you and your spouse were no longer eligible to enroll in a qualified health plan through NYSOH, effective January 31, 2017.

NYSOH is required to determine whether individuals are eligible to enroll in coverage through NYSOH, and must confirm, among other things, that their immigration status is satisfactory.

If NYSOH cannot verify an individual's immigration status, it must provide the individual with notice of the inconsistency. NYSOH must then provide the individual with a period of 90 days from the date notice is received to resolve the inconsistency. For purposes of verifying immigration status, notice is considered received 5 days after the date on the notice.

In the eligibility determination issued on December 16, 2016, you were advised that your and your spouse's eligibility was only conditional, and that you needed to confirm your and your spouse's immigration status before January 4, 2017.

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).

NYSOH did not receive the requested citizenship documentation before the deadline.

However, you testified and the record reflects that you elected to receive alerts regarding notices from NYSOH electronically. You credibly testified that you did not receive an electronic alert regarding the eligibility determination notice, which directed you that your eligibility was only conditional and that you needed to submit documentation to confirm your citizenship status. There is also no evidence in your account documenting that any email alert was sent to you regarding the need to submit documentation.

Therefore, it is concluded that NYSOH did not give you the proper notice that you needed to submit documentation of your citizenship.

Since you were not made aware of and did not receive proper notice that there was an inconsistency in your NYSOH account, the January 11, 2017, eligibility determination stating that you and your spouse are no longer eligible to remain enrolled in a qualified health plan for failure to submit documentation was improper and is **RESCINDED**.

Your case is **RETURNED** to NYSOH to assist you and your spouse in reenrolling into a health plan for coverage with an effective date of February 1, 2017, if you so choose. If not, you will have 60 days from the date of this decision to choose a health plan and enroll. You will be responsible for any unpaid premiums if you choose to backdate coverage.

## **Decision**

The January 11, 2017, eligibility determination notice is **RESCINDED**.

Your case is **RETURNED** to NYSOH to assist you and your spouse in reenrolling into a health plan for coverage with an effective date of February 1, 2017, if you so choose. If not, you will have 60 days from the date of this decision to choose a health plan and enroll. You will be responsible for any unpaid premiums if you choose to backdate coverage.

**Effective Date of this Decision:** July 13, 2017

## **How this Decision Affects Your Eligibility**

NYSOH erred in disenrolling you and your spouse from your qualified health plan effective January 31, 2017, without the proper notice.

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).

Your case is being sent back to NYSOH to assist you in reenrolling into a health plan for coverage as of February 1, 2017, if you so choose, or a plan within 60 days from the date of this decision.

### **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:

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 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 January 11, 2017, eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to assist you and your spouse in reenrolling into a health plan for coverage with an effective date of February 1, 2017, if you so choose. If not, you will have 60 days from the date of this decision to choose a health plan and enroll. You will be responsible for any unpaid premiums if you choose to backdate coverage.

NYSOH erred in disenrolling you and your spouse from your qualified health plan effective January 31, 2017, without the proper notice.

Your case is being sent back to NYSOH to assist you in reenrolling into a health plan for coverage as of February 1, 2017, if you so choose, or a plan within 60 days from the date of this decision.

## **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 مجاناً.

### বাংলা (Bengali)

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).

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 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&btumi ama wo obi a okyerE 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 דאלמענטשער 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).

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).