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

Notice of Decision

Decision Date: September 05, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000018696

Dear ,

On August 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 18, 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).

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

Decision

Decision Date: September 05

NY State of Health Account ID:
Appeal Identification Number: AP000000018696

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 were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective as of May 1, 2017?

Procedural History

On July 28, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan for a limited time wit no monthly, effective September 1, 2016. The notice directed you to submit additional income documentation to confirm your eligibility before October 25, 2016.

On July 28, 2016, NYSOH issued a plan enrollment notice confirming that as of July 27, 2016, you were enrolled in an Essential Plan 2, with an enrollment start date of September 1, 2016. The notice directed you to submit additional income documentation to confirm your eligibility before October 25, 2016.

On August 2, 2016, your NYSOH account was systemically updated.

On August 3, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, effective September 1, 2016.

On March 17, 2017, your NYSOH account was updated.

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On March 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 premium per month, effective May 1, 2017.

On March 18, 2017, NYSOH issued a plan enrollment notice confirming that as of March 17, 2017, you were enrolled in an Essential Plan 1, with an enrollment start date of September 1, 2016.

On May 4, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as you were billed $20.00 for the monthly premium and copayments in the month of April 2017.

On August 17, 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) According to your NYSOH account and testimony, you were enrolled in an Essential Plan with no monthly premium, effective September 1, 2016.

2) According to your account, on March 17, 2017 you reported an increase in your annual household income.

3) On March 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 premium per month, effective May 1, 2017 (*see* Document [redacted]).

4) You testified that your health plan billed you $20.00 for the monthly premium and charged you approximately $200.00 for copayments for medical services received in April 2017.

5) You testified that your eligibility for financial assistance should not have changed until May 1, 2017.

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

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Applicable Law and Regulations

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).

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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

A person who has a household income that is above 150% of the FPL has a $20.00 premium contribution and has higher cost-sharing (New York's Basic Health Plan Blueprint, pgs. 23-24, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

Redetermination During a Benefit Year

NYSOH requires that enrollees report any change with respect to their eligibility within 30 days of such change (42 CFR § 600.340(a), 45 CFR § 155.330(b)). NYSOH must implement changes resulting from a redetermination effective the first day of the month after NYSOH is notified of the change. However, NYSOH must implement a change that results in a decreased amount of financial assistance, and for which the date of the notice is after the 15th of the month, to be effective on the first day of the second month after NYSOH has been notified of the change (45 CFR §§ 155.330(f)(1)(iii), 155.330 (f)(3), New York's Basic Health Plan Blueprint, p. 18, 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 eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective as of May 1, 2017.

On July 28, 2016, NYSOH issued notices stating that you were eligible for and enrolled in an Essential Plan with no monthly premium, effective September 1, 2016.

The record shows that on March 17, 2017, the information in your NYSOH account was changed to reflect an increase in your annual household income. Based on that update, on March 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, effective as of May 1, 2017 (*see* [redacted]).

An enrollee must report any change to NYSOH that may affect their eligibility. Generally, when an individual changes the information in their account, any change resulting from that update will be effective the first day of the month after NYSOH is notified of the change. However, NYSOH must implement a change that results in a decreased amount of financial assistance, and for which the date of the notice is after the 15th of the month, to be effective on the first day of the second month after NYSOH has been notified of the change.

The record reflects that the March 17, 2017 update to your account resulted in a higher monthly premium and less cost-sharing. Furthermore, the corresponding notice was issued on March 18, 2017. Therefore, the change in your eligibility for financial assistance should have been effectuated as of May 1, 2017.

The March 18, 2017, eligibility determination notice properly stated that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective May 1, 2017, and is AFFIRMED.

You testified that you were billed $20.00 by the health plan for the April 2017 monthly premium and charged copayments for medical services received in the month of April 2017. Therefore, your case will be RETURNED to Plan Management to ensure that your health plan has properly complied with this decision, and to notify you accordingly.

Decision

The March 18, 2017, eligibility determination notice is AFFIRMED.

Your case will be RETURNED to the NYSOH's Plan Management Unit to ensure that your health plan has properly complied with this decision, and to notify you accordingly.

Effective Date of this Decision: September 05, 2017

How this Decision Affects Your Eligibility

You were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective May 1, 2017.

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):

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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- 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 March 18, 2017, eligibility determination notice is AFFIRMED.

Your case will be RETURNED to the NYSOH's Plan Management Unit to ensure that your health plan has properly complied with this decision, and to notify you accordingly.

You were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective May 1, 2017.

Legal Authority

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

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.

□□□□□ (Bengali)

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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 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.

(Urdu)اردو

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 פארשטייין, 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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