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

Notice of Decision

Decision Date: December 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021636

[redacted]

[redacted]

On November 3, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 16, 2017 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
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Decision

Decision Date: December 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021636

[redacted]

Issue

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

> Was your appeal of NY State of Health's (NYSOH) May 16, 2017 disenrollment notice timely?
>
> Did NYSOH properly determine that your, your spouse's, and your youngest child's eligibility for the Essential Plan ended effective June 1, 2017?

Procedural History

On April 18, 2017, NYSOH issued an eligibility determination notice, based on the April 17, 2017 application, stating that you, your spouse, and your youngest child were eligible for the Essential Plan for a limited time, effective June 1, 2017. You were directed to provide proof of income for you and your spouse by July 13, 2017, and for your youngest child by July 16, 2017.

Also on April 18, 2017, NYSOH issued an enrollment confirmation notice, stating that you, your spouse, and your youngest child were enrolled in the Essential Plan, effective June 1, 2017.

On May 15, 2017, you submitted an updated application for financial assistance with health insurance.

On May 16, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data

sources. You were directed to provide proof of your household's income by May 30, 2017.

Also on May 16, 2017, NYSOH issued a disenrollment notice, stating that your, your spouse's, and your youngest child's enrollment with the Essential Plan would end on June 1, 2017.

On May 30, 2017, you submitted an updated application for financial assistance with health insurance.

On May 31, 2017, NYSOH issued a notice of eligibility redetermination stating that you, your spouse, and your youngest child were newly eligible to receive up to $994.00 per month in advance payments of the premium tax credits (APTC) and, if you selected a silver-level qualified health plan, for cost-sharing reductions (CSR). This eligibility was effective July 1, 2017.

On June 27, 2017, NYSOH issued a letter confirming your, your spouse's, and your youngest child's enrollment in a qualified health plan with a monthly premium responsibility of $331.19, after your APTC of $994.00 was applied, both effective August 1, 2017.

On July 21, 2017, NYSOH issued a letter confirming your, your spouse's, and your youngest child's enrollment in a qualified health plan with a monthly premium responsibility of $331.19, after your APTC of $994.00 was applied, both effective July 1, 2017.

On August 21, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination and enrollment confirmation notices insofar as you, your spouse, and your youngest child did not have coverage in June 2017.

On November 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 support the following findings of fact:

1) You testified that you are appealing the lack of coverage for you, your spouse, and your youngest child for the month of June 2017.

2) The application that was submitted on April 18, 2017 listed an annual expected income of $29,403.00 for you, and $6,600.00 for your spouse.

3) Your application states that you will be filing your taxes as married filing jointly, and plan to claim your youngest child as a dependent on that tax return.

4) On May 7, 2017, you faxed copies of your paystubs to NYSOH.

5) On May 15, 2017, your household's application was updated to indicate that you wanted your household's eligibility determined on the income you received that month. The application stated that in May 2017 your household received $0.00. The application also listed annual expected income of $29,403.00 for you, and $6,600.00 for your spouse.

6) On May 29, 2017, you uploaded documentation of your income into your NYSOH account.

7) On May 30, 2017, your household's application was updated to indicate that you wanted your household's eligibility determined on your annual household income of $48,760.00, consisting of $47,260.01 you earn from your employment and $1,500.00 your spouse earns from his employment.

8) On June 26, 2017, you, your spouse, and your youngest child were enrolled into a qualified health plan. That enrollment was effective August 1, 2017, and was subsequently backdated to begin on July 1, 2017.

9) The record reflects that June 2017 is the only month in which you, your spouse, and your youngest child do not have coverage.

10) The record reflects that you contacted NYSOH on June 27, 2017, and complaints [redacted] were generated to address the gap in coverage for you, your spouse, and your youngest child.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45

CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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 $20,160.00 for a three-person household (81 Fed. Reg. 4036.).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $20,420.00 for a three-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's May 16, 2017 disenrollment notice was timely.

The record reflects that you filed an appeal with NYSOH regarding your, your spouse's, and your youngest child's disenrollment on August 21, 2017.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of the notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your, your spouse's, and your youngest child's disenrollment as stated in the May 16, 2017 notice, an appeal should have been filed by July 15, 2017.

Although your appeal was untimely on its face with regard to the May 16, 2017 notice, the record reflects that you spoke with NYSOH on June 27, 2017 regarding your, your spouse's, and your youngest child's enrollment, as noted in complaints [redacted]

As you originally contacted NYSOH within sixty (60) days of May 16, 2017 disenrollment notice that stated that you, your spouse, and your youngest child were disenrolled from Essential Plan coverage effective June 1, 2017, your

failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal.

The second issue whether NYSOH properly determined that your, your spouse's, and your youngest child's eligibility for the Essential Plan ended effective June 1, 2017.

On April 18, 2017, NYSOH received your household's application listing an annual household income of $36,003.00. As a result, you, your spouse, and your youngest child were found eligible for the Essential Plan for a limited time and enrolled in a plan as of June 1, 2017.

On May 15, 2017, your household's application was updated to indicate that you wanted your, your spouse's, and your youngest child's eligibility determined on the income received that month. The application stated that in May 2017 your household received $0.00.

According to the record, you expect to file a joint federal income tax return for the 2017 tax year and claim your youngest child as a dependent. Therefore, you, your spouse, and your youngest child are in a three-person household.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

To be eligible for Medicaid, you, your spouse, and your youngest child would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,349.00 per month. Since you attested to a monthly household income of $0.00 in the month of May 2017, you, your spouse, and your youngest child would be Medicaid eligible if you provided sufficient documentation to confirm your attestation.

A Medicaid-eligible individual with an income no greater than 138% of the FPL does not qualify to enroll in the Essential Plan. Therefore, since you had updated your application to reflect income that was within the Medicaid limit, you, your spouse, and your youngest child would be no longer eligible for the Essential Plan. You, your spouse, and your youngest child were subsequently and properly disenrolled from Essential Plan coverage effective June 1, 2017, because you were no longer eligible to remain enrolled in that plan.

Therefore, the May 16, 2017 disenrollment notice stating that you, your spouse, and your youngest child were no longer enrolled in the Essential Plan effective June 1, 2017, is AFFIRMED.

Decision

The May 16, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: December 13, 2017

How this Decision Affects Your Eligibility

This decision does not change your, your spouse's or your youngest child's eligibility.

You, your spouse, and your youngest child were properly disenrolled from you Essential Plan coverage as of June 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):

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 May 16, 2017 disenrollment notice is AFFIRMED.

This decision does not change your, your spouse's or your youngest child's eligibility.

You, your spouse, and your youngest child were properly disenrolled from you Essential Plan coverage as of June 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:

[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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