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

Notice of Decision

Decision Date: November 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022858

[redacted]

[redacted]

On November 17, 2017, you and your Authorized Representative appeared by telephone at a hearing on your appeal of NY State of Health's September 30, 2017 eligibility determination.

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 NY State of Health 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: November 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022858

[redacted]

Issues

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 no longer eligible for the Essential Plan, effective November 1, 2017?

Procedural History

On October 6, 2016, NYSOH issued a notice stating that you were eligible for the Essential Plan with a $20.00 monthly premium, effective November 1, 2016.

On October 9, 2016, NYSOH issued an enrollment confirmation stating that you were enrolled in an Essential Plan with an effective start date of November 1, 2016.

On September 3, 2017, NYSOH issued a renewal notice stating that based on information received from federal and state sources, NYSOH did not have enough information to determine if you could get help paying for your health insurance. The notice directed you to update your application by October 15, 2017.

On September 19, 2017, you submitted several applications for financial assistance.

On September 22, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan, effective November 1, 2017.

Also on September 22, 2017, NYSOH issued a disenrollment notice stating that you were no longer eligible for the Essential Plan and that your coverage was ending effective October 31, 2017.

On September 27, 2017, you spoke to NYSOH's Account Review Unit and appealed your disenrollment from the Essential Plan.

On September 30, 2017, NYSOH issued an eligibility determination stating that, based on an application submitted on September 19, 2017, that you were no longer eligible for Medicaid but your Medicaid coverage would continue until August 31, 2017.

On November 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [redacted] acted as your Authorized Representative and assisted you with your testimony. The record was developed during the hearing and held open until November 29, 2017, to allow you to submit supporting documents.

Also on November 17, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1, the record was closed that day.

Findings of Fact

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

1) You were determined eligible for an Essential Plan with a $20.00 monthly premium, effective November 1, 2016 and you subsequently enrolled in an Essential Plan.

2) On September 3, 2017, NYSOH issued a renewal notice directing you to update your application by October 15, 2017.

3) Your Authorized Representative testified that he met with you on September 19, 2017 to update your NYSOH application.

4) Your Authorized Representative testified that during the application process on September 19, 2017 he asked you what was your estimated annual income for 2017.

5) Your Authorized Representative testified that he believed that you said "$16,000.00" when, if fact, you said $1,600.00 and you were referring to your monthly income. Your Authorized Representative testified that you are from [redacted] your English is difficult to understand.

6) Your Authorized Representative testified that he entered $16,000.00 as your estimated 2017 income. You testified that you corrected him stating that your estimated annual income for 2017 was $19,200.00.

7) NYSOH records reflect that based on the income of $16,000.00 being entered as your annual income, you were placed in a pending Medicaid status.

8) Your Authorized Representative testified that he thereafter entered your estimated annual income as $19,200.00 (also on September 19, 2017).

9) NYSOH records reflect that you then were redetermined no longer eligible for Medicaid but granted continuous Medicaid coverage through August 31, 2018.

10) Your Authorized Representative testified that he called NYSOH on several occasions on September 19, 2017 but was unable to have the mistake corrected and have your eligibility and enrollment in the Essential Plan reinstated.

11) Your Authorized Representative testified that on September 19, 2017, a NYSOH representative advised him that you should enroll in a Medicaid Managed Care plan, file an appeal and wait for the results of the appeal.

12) NYSOH records reflect that you were disenrolled from your Essential Plan, effective October 31, 2017.

13) Your Authorized Representative testified and NYSOH records reflect that you enrolled in a Medicaid Managed Care plan with an effective start date of November 1, 2017.

14) Your Authorized Representative testified that you are uncomfortable receiving Medicaid coverage because you do not feel entitled to it based on your annual income of $19,200.00.

15) Your Authorized Representative testified that you are eligible for the Essential Plan and not Medicaid and that you are seeking to be reinstated into an Essential Plan.

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

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 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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible for the Essential Plan, effective November 1, 2017.

You were determined eligible for an Essential Plan with a $20.00 monthly premium, effective November 1, 2016 and you subsequently enrolled in an Essential Plan.

On September 3, 2017, NYSOH issued a renewal notice directing you to update your application by October 15, 2017.

Your Authorized Representative testified that he met with you on September 19, 2017 to update your NYSOH application. Your Authorized Representative testified that during the application process on September 19, 2017 he asked you what was your estimated annual income for 2017. Your Authorized Representative testified that he believed that you said "$16,000.00" when, if fact, you said $1,600.00 and you were referring to your monthly income. Your Authorized Representative testified that you are from [redacted] your English is difficult to understand.

Your Authorized Representative testified that he entered $16,000.00 as your estimated 2017 income. You testified that you corrected him stating that your estimated annual income for 2017 was $19,200.00. NYSOH records reflect that based on the income of $16,000.00 being entered as your annual income, you were placed in a pending Medicaid status.

Your Authorized Representative testified that he thereafter entered your estimated annual income as $19,200.00 (also on September 19, 2017). NYSOH records reflect that you then were redetermined no longer eligible for Medicaid but granted continuous Medicaid coverage through August 31, 2018.

Your Authorized Representative testified that he called NYSOH on several occasions on September 19, 2017 but was unable to have the mistake corrected and your eligibility and enrollment in the Essential Plan reinstated.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $19,200.00 is 161.61% of the 2016 FPL, NYSOH should have found you to be eligible for the Essential Plan with a $20.00 monthly premium.

The NYSOH Appeals Unit finds that this error should have been corrected by NYSOH on September 19, 2017 when your Authorized Representative reported that he inadvertently entered the incorrect amount of your annual income.

Therefore, the September 30, 2017 eligibility determination notice is RESCINDED and your case is being RETURNED to NYSOH to reinstate you into your Essential Plan with a $20.00 monthly premium, effective December 1, 2017.

Decision

The September 30, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to reinstate you into your Essential Plan with a $20.00 monthly premium, as soon as it can be effectuated.

Effective Date of this Decision: November 30, 2017

How this Decision Affects Your Eligibility

You are eligible for the Essential Plan.

Your case is being RETURNED to NYSOH to reinstate you into your Essential Plan with a $20.00 monthly premium, as soon as it can be effectuated.

NYSOH will notify you when these changes are made.

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 September 30, 2017 eligibility determination notice is RESCINDED.

You are eligible for the Essential Plan.

Your case is being RETURNED to NYSOH to reinstate you into your Essential Plan with a $20.00 monthly premium, as soon as it can be effectuated.

NYSOH will notify you when these changes are made.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

[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.

□□□□□ (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.

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)

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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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