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

Notice of Decision

Decision Date: February 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025419

[redacted]

[redacted]

On February 9, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 7, 2017 eligibility determination notice and November 7, 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: February 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000025419

[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 were no longer eligible for health insurance through NYSOH effective December 1, 2017?

Procedural History

On February 1, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for up to $273.00 per month in advance payments of the premium tax credit, effective March 1, 2017.

Also on February 1, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a qualified health plan with a plan enrollment start date of March 1, 2017 and that your advance premium tax credit would be applied to your monthly premium effective March 1, 2017.

On October 28, 2017, NYSOH issued a notice stating that NYSOH had received information for the United States Postal Service (USPS) that your address had changed. This notice directed you to make sure that NYSOH had your current mailing and residential address. This notice was sent to [redacted]

Also on October 28, 2017, NYSOH issued a renewal notice stating that you qualified for up to $239.97 per month in advance payments of the premium tax credit, effective January 1, 2018. This notice was sent to [redacted],

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[redacted] On November 3, 2017, this notice was returned to NYSOH by the USPS as a forwarding addressed had been provided, but mail from NYSOH cannot be forwarded. The forwarding address provided was [redacted]

On November 6, 2017, NYSOH redetermined your eligibility.

On November 7, 2017, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for health insurance through NYSOH. You did not qualify for Medicaid, for Child Health Plus or the Essential Plan, to receive advance payments of the premium tax credit or cost-sharing reductions, or to purchase a qualified health plan, effective December 1, 2017. This was because you were not a resident of New York State.

Also on November 7, 2017, NYSOH issued a disenrollment notice stating that your coverage with your qualified health plan would end on November 30, 2017. This was because you were no longer eligible to enroll in coverage through NYSOH.

On December 6, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as it ended your eligibility and enrollment on November 30, 2017.

On February 9, 2018, 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) You testified that you relocated from [redacted] on a full-time basis as of December 1, 2017.

2) You explained that you had been traveling back and forth from [redacted] throughout October 2017 and November 2017.

3) You testified that you previously resided at [redacted] from 2015 until September 2017.

4) You explained that throughout October 2017 and November 2017 you were splitting your time between residing at your brother's home in [redacted] New York, [redacted]

5) You testified that you work as [redacted] and the organizations that you work for are based in New York and Chicago.

6) You testified that in part of June 2017, October 2017, and part of November 2017 you were living at [redacted], [redacted] [redacted].

7) You testified that you set-up mail forwarding with the USPS sometime in late October 2017.

8) On October 28, 2017, NYSOH received information from the USPS that you had a change of address.

9) On November 6, 2017, NYSOH updated your address to [redacted] based on a forwarding address on mail which was returned by the USPS.

10) You testified that you are seeking enrollment through NYSOH for the month of November 2017 only. You explained that you sought medical care at [redacted] in November 2017 and that your qualified health plan has not paid for this treatment.

11) Your NYSOH account indicates that you were enrolled in a qualified health plan through NYSOH from March 1, 2017 through November 30, 2017.

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

Applicable Law and Regulations

State Residency Requirement

Generally, an applicant is eligible for enrollment in a qualified health plan (QHP) through NYSOH if he: (1) is a citizen or national of the United States; (2) is not incarcerated; and (3) is a resident of the state (45 CFR § 155.305(a)(1)-(3)).

NYSOH must verify an applicant's attestation that the applicant is a resident of the state by either relying on available electronic data sources, or accepting the applicant's attestation when electronic data sources are unavailable (45 CFR § 155.315(d)). However, if an applicant's attestation is not reasonably compatible with information from approved data sources or other information provided by the applicant, NYSOH must notify the applicant of the inconsistency and provide the applicant with a period of 90 days to present documentation to resolve the inconsistency (45 CFR § 155.315(d)(4); 45 CFR § 155.315(f)(2)(i)-(ii)).

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

APTC Eligibility

APTC are generally available to a person who is eligible to enroll in a qualified health plan and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were no longer eligible for health insurance through NYSOH effective December 1, 2017.

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

You were enrolled in a qualified health plan with advance payments of the premium tax credit, effective March 1, 2017. However, the October 28, 2017 renewal notice was returned to NYSOH as you had provided a forwarding address and mail from NYSOH cannot be forwarded. The USPS provided a forwarding address of [redacted].

As a result, NYSOH redetermined your eligibility and issued a notice of eligibility determination stating that you were no longer eligible to enroll in health insurance through NYSOH, effective December 1, 2017. This was because you were no longer a resident of New York State.

In order to be qualified to enroll in health insurance through NYSOH, an individual must be a resident of New York State.

You testified that throughout October 2017 and November 2017 you were traveling back and forth between New York State and Rhode Island. However, as of December 1, 2017, you had established residency in Rhode Island.

As you were no longer a resident of New York State, NYSOH properly determined that you were no longer eligible to enroll in coverage through NYSOH effective December 1, 2017.

Therefore, the November 7, 2017 eligibility determination which stated that you were no longer eligible to enroll in coverage through NYSOH effective December 1, 2017 and the November 7, 2017 disenrollment notice stating that you were disenrolled from your qualified health plan effective November 30, 2017 are AFFIRMED.

Decision

The November 7, 2017 eligibility determination is AFFIRMED.

The November 7, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: February 14, 2018

How this Decision Affects Your Eligibility

Your coverage in your qualified health plan through NYSOH properly ended as of November 30, 2017 because you were no longer a New York State resident as of December 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 November 7, 2017 eligibility determination is AFFIRMED.

The November 7, 2017 disenrollment notice is AFFIRMED.

Your coverage in your qualified health plan through NYSOH properly ended as of November 30, 2017 because you were no longer a New York State resident as of December 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)

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।

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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)

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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