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

Notice of Decision

Decision Date: April 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000031139

[redacted]

[redacted]

On April 9, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 28, 2018 denial 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 NY State of Health number 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: April 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000031139

[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 did not qualify to enroll in a qualified health plan at full cost, as of February 27, 2018?

Procedural History

On February 21, 2018, you created an account with NYSOH and submitted an application for financial assistance with health insurance to NYSOH. The data sources in that application indicated that you were eligible for Medicare.

On February 22, 2018, NYSOH issued a denial notice, based on the February 27, 2018 application, stating that you did not qualify for Medicaid in part because you had Medicare and were not younger than 19, aged 19 to 20 and living with parents, or the parent or caretaker of a child younger than 19; and your household income was over the allowable limit. The notice also stated that you did not qualify for the Essential Plan, premium tax credit and cost-sharing reductions, or a qualified health plan at full cost because NYSOH's information showed that you had Medicare and individuals with Medicare cannot get health insurance through NYSOH.

On February 27, 2018, you resubmitted an application for health insurance with NYSOH.

On February 28, 2018, NYSOH issued a denial notice, based on the February 27, 2018 application, stating that you did not qualify for Medicaid in part because you had Medicare and were not younger than 19, aged 19 to 20 and living with parents, or the parent or caretaker of a child younger than 19; and your household income was over the allowable limit. The notice also stated that you did not qualify for the Essential Plan, premium tax credit and cost-sharing reductions, or a qualified health plan at full cost because NYSOH's information showed that you had Medicare and individuals with Medicare cannot get health insurance through NYSOH.

On April 2, 2018, you contacted NYSOH's Account Review Unit and requested an appeal insofar as you were determined ineligible for health insurance through NYSOH.

On April 3, 2018, NYSOH received your request for an expedited hearing.

On April 4, 2018, your request for an expedited hearing was approved and you were scheduled for a telephone hearing.

On April 9, 2018, you had an expedited telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Under oath, you waived your right to formal notice of the hearing. 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 are appealing specifically to be found eligible to enroll in a qualified health plan at full cost.

2) You testified that you had COBRA insurance, through your previous employer, from March 1, 2015 to March 31, 2018. You further testified that this was the max period that you were entitled to COBRA coverage.

3) You testified that you applied for Social Security disability benefits prior to [redacted] in 2004 or 2005. You further testified that you became eligible for Medicare Parts A and B in 2006.

4) According to your NYSOH account, you have been entitled to Medicare since September 1, 2006.

5) On April 8, 2018, you uploaded a letter from the Social Security Administration, dated March 28, 2018. This letter reflects that you are currently entitled to disability based Medicare Part A from September 2006

through the last day of August 2018. The letter further reflects that your entitlement to Medicare Part B benefits ended October 2013 and that you are not eligible to re-enroll due to the cessation of your disability.

6) You testified that you did not know you were still entitled to Medicare Part A. You further testified that you have not had a Medicare Part A claim in over three years.

7) You testified that you attempted to have your Medicare Part A end prior to the end of August, but were told that you could not.

8) You testified that you need insurance because you cannot afford to pay for your needed medication out of pocket.

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

Applicable Law and Regulations

Qualified Health Plan

It is unlawful for a person to sell or issue to an individual, entitled to benefits under Medicare Part A or enrolled under Medicare Part B, a health insurance policy with the knowledge that the policy duplicates health benefits to which the individual is otherwise entitled to be enrolled in (42 U.S. Code § 1395ss(d)(3)(A); https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf (last updated April 28, 2016).

Legal Analysis

The issue under review is whether NYSOH properly determined that you did not qualify to enroll in a qualified health plan at full cost.

On February 21, 2018, you created an account through NYSOH and submitted an initial request for coverage. There is no indication that you were enrolled into coverage through NYSOH at any point prior to the creation of your account on February 21, 2018.

On February 27, 2018, you submitted an additional application for financial assistance with health insurance to NYSOH. The data sources in that application indicated that you were eligible for Medicare Part A. As a result of this application, you were found not eligible to enroll in coverage through NYSOH in part because you were entitled to Medicare benefits.

Your Social Security Administration letter, dated March 2, 2018, reflects that you became entitled to Medicare Part A started September 2006 and your entitlement will end the last day of August 2018.

In order to enroll into a qualified health plan through NYSOH, an applicant cannot have duplicate coverage in Medicare. The sale or issuance of duplicate health insurance coverage to Medicare beneficiaries, including qualified health plans through NYSOH, is prohibited. NYSOH data sources reflect, and your letter from the Social Security Benefits Administration confirms, that you have been eligible for Medicare Part A since September 2006. Therefore, NYSOH properly determined that you did not qualify to enroll in a qualified health plan at full cost due to you having access to Medicare Part A at the time of your February 27, 2018 application.

Since you were eligible for Medicare Part A coverage at the time of your February 27, 2018 application, the February 28, 2018 denial notice is correct and is AFFIRMED.

Decision

The February 28, 2018 denial notice is AFFIRMED.

Effective Date of this Decision: April 10, 2018

How this Decision Affects Your Eligibility

You are ineligible for health insurance through NYSOH.

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 February 28, 2018 denial notice is AFFIRMED.

You are ineligible for health insurance through NYSOH.

Legal Authority

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

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).

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।

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).

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 नि:शुल्क 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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