



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

## Notice of Decision

Decision Date: April 20, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014263

[REDACTED]

Dear [REDACTED],

On March 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 20, 2016 enrollment 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 at the top of this notice.

### Legal Authority

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

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: April 20, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000014263

[REDACTED]

## Issue

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

Did New York State of Health (NYSOH) properly determine that your Essential Plan should begin effective February 1, 2017?

## Procedural History

On November 8, 2016, you submitted an application for financial assistance through NYSOH.

On November 9, 2016, NYSOH issued a notice stating that the income information in your November 8, 2016 application did not match what NYSOH received from state and federal data sources. The notice directed you to provide additional proof of income by November 23, 2016 to confirm your eligibility.

On December 11, 2016 and December 12, 2016, you uploaded additional income and employment documentation to your NYSOH account ([REDACTED]).

On December 19, 2016, your NYSOH account was updated.

On December 20, 2016, 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 February 1, 2017.

Also on December 20, 2016, NYSOH issued an enrollment notice confirming that as of December 19, 2016, you were enrolled in an Essential Plan with an enrollment start date of February 1, 2017.

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On December 22, 2016, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as the start date of your Essential Plan.

On March 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH Appeals Unit. Testimony was taken during the hearing, and the record closed at the end of the proceeding.

## Findings of Fact

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

- 1) According to your NYSOH account and testimony, you are applying for health insurance for yourself.
- 2) You testified that your employment with ██████████ ended in November 2016, and your employer-sponsored insurance was terminated November 30, 2016.
- 3) According to your NYSOH account, you uploaded the following documentation to your account on December 11, 2016;
  - (a) A letter from ██████████ stating that your employment status was changed from part-time status to a layoff effective November 11, 2016 (██████████);
  - (b) A chart demonstrating your total invoiced income from self-employment from January 1, 2016 through November 30, 2016 (██████████);
  - (c) A December 8, 2016, biweekly earnings statement from ██████████ (██████████).
- 4) According to your NYSOH account, a November 23, 2016 biweekly earnings statement from ██████████ was uploaded to your account on December 12, 2016 (██████████).
- 5) According to the notes in your NYSOH account, the income and employment documentation was determined to be valid on December 19, 2016.
- 6) You testified that you enrolled in the Essential Plan on December 19, 2016, with an enrollment start date of February 1, 2017.
- 7) You testified that you are seeking an enrollment start date of December 1, 2016.

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 Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); see also 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

### Essential Plan – Income Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow the NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f); 42 CFR §600.345 (a)) See also New York's Basic Health Plan Blueprint, p. 17, 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 your enrollment in your Essential Plan was effective February 1, 2017.

Your NYSOH account was updated on November 8, 2016. The income amount that was entered into this application did not match federal and state data sources. As a result, on November 9, 2016 NYSOH issued a notice directing you to submit additional income documentation to confirm your eligibility.

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine

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eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

On December 11, 2016, and December 12, 2016, income and employment documentation was uploaded to your NYSOH account, and that documentation was determined to be valid on December 19, 2016.

The date on which an Essential Plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

The record supports that the income documentation provided to NYSOH on December 11, 2016, and December 12, 2016 was determined to be valid. Therefore, NYSOH had sufficient information to render an eligibility determination as of December 12, 2016.

Therefore, the December 20, 2016, enrollment notice is MODIFIED to state that you were enrolled in an Essential Plan with an enrollment start date of January 1, 2017.

Your case is RETURNED to NYSOH to effectuate your Essential Plan coverage from January 1, 2017 through January 31, 2017.

## **Decision**

The December 20, 2016, enrollment notice is MODIFIED to state that you were enrolled in an Essential Plan with an enrollment start date of January 1, 2017.

Your case is RETURNED to NYSOH to effectuate your Essential Plan coverage from January 1, 2017 through January 31, 2017.

**Effective Date of this Decision:** April 20, 2017

## **How this Decision Affects Your Eligibility**

Your Essential Plan enrollment start date is January 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.

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).

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

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## **Summary**

The December 20, 2016, enrollment notice is MODIFIED to state that you were enrolled in an Essential Plan with an enrollment start date of January 1, 2017.

Your case is RETURNED to NYSOH to effectuate your Essential Plan coverage from January 1, 2017 through January 31, 2017.

Your Essential Plan enrollment start date is January 1, 2017.

## **Legal Authority**

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



**A Copy of this Decision Has Been Provided To:**



## 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 1-855-355-5777번으로 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 مجاناً.

### 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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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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