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

Notice of Decision

Decision Date: July 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016388

[redacted]

Dear [redacted]

On June 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 26, 2017 disenrollment notice and February 28, 2017 enrollment confirmation 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: July 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016388

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that your Essential Plan coverage ended effective February 28, 2017?
>
> Did NYSOH properly determine that your re-enrollment in an Essential Plan was effective April 1, 2017?

Procedural History

On January 10, 2017, you submitted an application for financial assistance to NYSOH with an expected annual income of $20,000.00.

On January 11, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for an Essential Plan, effective February 1, 2017.

Also on January 11, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in an Essential Plan with a start date of February 1, 2017.

On January 25, 2017, you updated your application for financial assistance, decreasing your expected annual income from $20,000.00 to $5,627.10.

On January 26, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal

sources. The notice directed you to provide proof of income by February 9, 2017. The notice also stated that if you missed the due date, you might lose your insurance or receive less help paying for your coverage. Finally, the notice stated that if you received wages and salary, to provide NYSOH with paycheck stubs for the last 4 weeks.

Also on January 26, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan coverage was ending effective February 28, 2017 because you were no longer eligible to enroll in the Essential Plan.

On February 6, 2017, you uploaded income documentation consisting of one biweekly pay stub and your W-2 Tax Statement for 2016 (&).

On February 17, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the information in your application. The notice directed you to provide proof of income by March 11, 2017.

On February 27, 2017, you updated your application for financial assistance increasing your expected annual income to $22,000.00.

On February 28, 2017, NYSOH issued a notice of eligibility determination, based on your February 27, 2017 application, stating that you were eligible to enroll in an Essential Plan, effective April 1, 2017.

Also on February 28, 2017, NYSOH issued a notice of enrollment, based on your plan selection on February 27, 2017, stating that you were enrolled in an Essential Plan, and that your plan would start April 1, 2017.

Also on February 28, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in the Essential Plan insofar as it did not begin March 1, 2017.

On June 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, acted as your Authorized Representative and assisted you with your testimony. 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 submitted an application for financial assistance on January 10, 2017 with an expected annual income of $20,000.00.

2) On January 10, 2017, you were determined eligible for the Essential Plan, effective February 1, 2017.

3) Also on January 10, 2017, you selected an Essential Plan with an enrollment start date of February 1, 2017.

4) On January 25, 2017, you updated your application for financial assistance decreasing your expected annual income to $5,627.10.

5) NYSOH records reflect that you were placed in a pending Medicaid status and disenrolled from your Essential Plan, effective February 28, 2017, based on this application.

6) On January 26, 2017 proof of income was requested by NYSOH by February 9, 2017. The notice stated that if you receive wages and salary to provide paycheck stubs for the last four weeks.

7) On February 6, 2017, you uploaded to your NYSOH account one biweekly pay stub with a pay date of January 13, 2017 and your W-2 Tax Statement for 2016 (see [redacted] & [redacted]).

8) NYSOH records reflect that on February 17, 2017, the income documentation you provided was determined invalid proof of income by NYSOH.

9) You were directed to provide proof of income by March 11, 2017.

10) You testified and NYSOH records reflect that you did not submit proof of income by March 11, 2017.

11) You submitted an updated application to NYSOH for financial assistance on February 27, 2017 listing an expected annual income of $22,000.00.

12) Also on February 27, 2017, you were determined eligible for the Essential Plan, effective April 1, 2017.

13) You testified, and the record reflects, that you enrolled in an Essential Plan on February 27, 2017 with an effective start date of April 1, 2017.

14) You testified that you wanted your enrollment in an Essential Plan to begin on March 1, 2017 because you incurred medical bills during the month of March 2017.

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

Applicable Law and Regulations

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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your Essential Plan coverage ended effective February 28, 2017.

You submitted an application for financial assistance on January 10, 2017 listing an expected annual income of $20,000.00. Also on January 10, 2017, you were determined eligible for the Essential Plan and selected a plan for enrollment on that date. Your eligibility and enrollment were effective February 1, 2017.

On January 25, 2017, you updated your application for financial assistance decreasing your expected annual income from $20,000.00 to $5,627.10.
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. On the date of your application, that was the 2016 FPL, which is $11,880.00 for a one-person household.

Because of the decrease in your expected annual income to $5,627.10, which NYSOH relied upon in determining your eligibility, you became tentatively eligible for Medicaid and ineligible for the Essential Plan. This resulted in your disenrollment from your Essential Plan, effective February 28, 2017. Therefore, the January 26, 2017 disenrollment notice was correct and is AFFIRMED.

The second issue under review is whether NYSOH properly determined that your enrollment in an Essential Plan was effective April 1, 2017.

You testified, and the record indicates, that you updated your NYSOH application on February 27, 2017. As a result, you were found eligible for the Essential Plan as of February 27, 2017 and enrolled into a plan that day.

The date on which enrollment in 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 goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

On February 27, 2017, you selected an Essential Plan, so your enrollment properly took effect on the first day of the following; that is, on April 1, 2017.

Therefore, the February 28, 2017 enrollment confirmation notice stating that your enrollment in the Essential Plan was effective April 1, 2017, is correct and must be AFFIRMED.

Decision

The January 26, 2017 disenrollment notice is AFFIRMED.

The February 28, 2017 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: July 19, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

The effective date of your Essential Plan is April 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 January 26, 2017 disenrollment notice is AFFIRMED.

The February 28, 2017 enrollment confirmation notice is AFFIRMED.

This decision does not change your eligibility.

The effective date of your Essential Plan is April 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:

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)

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).

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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