



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

## Notice of Decision

Decision Date: May 4, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018455

[REDACTED]

Dear [REDACTED]

On May 3, 2017, you appeared by telephone at an expedited hearing on your appeal of NY State of Health's April 21, 2017 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: May 4, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018455



## 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 your Essential Plan should begin effective June 1, 2017?

## Procedural History

On March 3, 2016, NYSOH issued an eligibility determination stating that you were eligible for Medicaid effective as of April 1, 2016.

Also on March 3, 2016, NYSOH issued an enrollment notice confirming that as of March 2, 2016, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of April 1, 2016.

On February 3, 2017, NYSOH issued a renewal notice stating that, based on federal and state sources, you now qualified for the Essential Plan with a monthly premium of \$20.00. The notice stated if anything has changed that would affect how you are covered or what you pay for health insurance, you need to make changes to your account between February 16, 2017 and March 15, 2017.

On February 16, 2016, your NYSOH account was systematically updated.

On February 17, 2017, NYSOH issued an enrollment notice stating that you have been automatically enrolled in an Essential Plan, with Fidelis Care, with an enrollment start date of April 1, 2017. The notice stated that you have been enrolled into this plan because it was similar to the coverage you had before with this insurance company.

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On April 21, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Essential Plan would end April 1, 2017, because you did not pay your insurance bill by the payment deadline.

On April 21, 2017, your NYSOH account was updated.

On April 22, 2017, 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 as of June 1, 2017.

Also on April 22, 2017, NYSOH issued an enrollment notice confirming that as of April 21, 2016, you were enrolled in an Essential Plan with a plan enrollment start date of June 1, 2017.

On April 27, 2017, you submitted an expedited appeal request to NYSOH insofar as the cancellation of your health insurance ([REDACTED]).

On May 3, 2017, you had an expedited telephone hearing with a Hearing Officer from NYSOH Appeals Unit. You waived formal notice of the telephone hearing. 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, you were found eligible for Medicaid coverage effective April 1, 2016.
- 2) According to your NYSOH account, you receive notices from NYSOH electronically.
- 3) You testified that you never received a notice from NYSOH stating that your Medicaid coverage had been discontinued or that you were enrolled in the Essential Plan with a \$20.00 monthly premium.
- 4) You testified that the email listed on your NYSOH account, [REDACTED] is your current email address.
- 5) You testified that you never received an email from NYSOH stating that notices were uploaded to your NYSOH account.
- 6) You testified that you first found out that your health insurance had been cancelled when you were at a pharmacy at the end of April 2017.

- 7) You testified that you contacted NYSOH regarding the cancellation of your health insurance, and a representative notified you that your coverage had been terminated for non-payment of premiums.
- 8) According to your NYSOH account, you reenrolled in an Essential Plan on April 21, 2017.
- 9) On April 27, 2017, you faxed a letter from [REDACTED] Hospital's [REDACTED] Group stating that you were under their care for the management of your [REDACTED]. The letter states that you require [REDACTED] daily or you could go into DKA and potentially die ([REDACTED]).
- 10) You testified you want your Essential Plan to have an enrollment start date of April 1, 2017.

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

## **Applicable Law and Regulations**

### Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every 12 months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates that may have been provided by the individual (45 CFR §155.335(h)).

### Electronic Notices

Applicants may choose to receive notices and information from NYSOH either by electronic alerts or by regular mail. If the applicant elects to receive electronic notices, NYSOH must send an email or other electronic communication alerting the individual that a notice has been posted to the applicant's account (42 CFR § 600.330(e); 42 CFR § 435.918(b)(4)).

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Additionally, if an electronic alert regarding a notice in an individual's NYSOH account fails, NYSOH must send out the notice by regular mail within three days of the failed alert (42 CFR § 435.918(b)(5)).

### 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 issue under review is whether NYSOH properly determined that your enrollment in your Essential Plan should be effective June 1, 2017.

You were initially found eligible for Medicaid effective April 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's February 3, 2017, renewal notice stated that, based on information from federal and state sources, you could not enroll in the same health plan for the next coverage year. The notice stated that you now qualified for the Essential Plan with a monthly premium of \$20.00. Furthermore, the notice stated that if anything had changed that would affect how you are covered or what you pay for health insurance, you need to make changes to your account between February 16, 2017 and March 15, 2017.

Because there were no updates to your account by March 15, 2017, your Medicaid coverage was terminated effective March 31, 2017, at the end of the 12-month coverage period. Furthermore, you were automatically enrolled in an Essential Plan, with a \$20.00 monthly premium, effective April 1, 2017.

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The record reflects that you elected to receive alerts regarding notices from NYSOH electronically. You credibly testified that you did not receive any electronic alert regarding the notice that informed you about your new eligibility and enrollment. There is no evidence in your account showing that any email alert was sent to you regarding the need to check your NYSOH account, that any such electronic notice failed, or that the notice was later sent to you by regular mail.

Therefore, it is concluded that NYSOH did not provide you with the required annual redetermination notice.

You testified that you first found out that your Medicaid coverage had been cancelled when you were at the pharmacy at the end of April 2017. It was not until you contacted NYSOH that you discovered that you had been enrolled in an Essential Plan, and your coverage was subsequently terminated for non-payment of premiums.

You updated your account and reenrolled in an Essential Plan on April 21, 2017. If you were properly notified of your new eligibility and enrollment, your Essential Plan would have begun on April 1, 2017.

Therefore, the April 21, 2017, enrollment notice is MODIFIED to state that your Essential Plan enrollment start date is April 1, 2017.

Your case is RETURNED to NYSOH to reinstate your Essential Plan coverage for the months of April and May 2017.

## **Decision**

The April 21, 2017, enrollment notice is MODIFIED to state that your Essential Plan enrollment start date is April 1, 2017.

Your case is RETURNED to NYSOH to reinstate your Essential Plan coverage for the months of April and May 2017.

**Effective Date of this Decision:** May 4, 2017

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

Your Essential Plan will begin effective April 1, 2017.

## **If You Disagree with this Decision (Appeal Rights)**

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).

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

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## **Summary**

The April 21, 2017, enrollment notice is MODIFIED to state that your Essential Plan enrollment start date is April 1, 2017.

Your case is RETURNED to NYSOH to reinstate your Essential Plan coverage for the months of April and May 2017.

Your Essential Plan will begin effective April 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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