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

Notice of Decision

Decision Date: December 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023260

[redacted]

Dear [redacted]

On December 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 11, 2017 plan 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 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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Decision

Decision Date: December 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023260

[redacted]

Issue

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

> Did NY State of Health properly determine that your enrollment in an Essential Plan was effective November 1, 2017?

Procedural History

On June 4, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating you were eligible for Medicaid, effective June 1, 2016. You subsequently enrolled in a Medicaid Managed Care plan, effective July 1, 2016.

On April 6, 2017, NYSOH issued a renewal notice stating it was time to renew your coverage for 2017. The notice stated you no longer qualified for financial assistance but you did qualify for a qualified health plan at full cost. The notice stated this was because state and federal data sources showed your household income was over $64,080.00. The eligibility was effective June 1, 2017.

On April 17, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan would end, effective May 31, 2017.

On May 12, 2017, NYSOH issued a notice of eligibility determination stating you were eligible to purchase a qualified health plan at full cost, effective June 1, 2017. The notice stated you did not qualify for Medicaid because federal and state data sources showed you were already enrolled in Medicaid.

On October 10, 2017, NYSOH received your updated application for financial assistance. That day a preliminary eligibility determination was prepared finding you eligible to enroll in the Essential Plan, effective November 1, 2017. You enrolled in a plan that day.

On October 10, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your enrollment in the Essential insofar as it did not begin October 1, 2017.

On October 11, 2017, NYSOH issued a notice of eligibility determination stating you were eligible for the Essential Plan for a cost of $20.00 per month, effective November 1, 2017.

On October 11, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan, effective November 1, 2017.

On December 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing kept open 15 days for you to provide supporting documentation.

On December 15, 2017, NYSOH received a four-page fax, which was made part of the record as Appellant's Exhibit 1. The record was then closed.

Findings of Fact

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

1) You were determined eligible for Medicaid June 1, 2016.

2) The record shows you were determined no longer eligible for Medicaid, effective June 1, 2017, as NYSOH determined from data sources your income was over the allowable income limit for that program.

3) You were disenrolled from your Medicaid Managed Care plan, effective May 31, 2017.

4) NYSOH determined that you were already receiving Medicaid on May 11, 2017.

5) Records through eMedNY show that your Medicaid coverage with your local district started June 1, 2017 and ended September 30, 2017.

6) You testified you were not aware your coverage with Medicaid with your local district would be ending September 30, 2017, until you received a letter stating this on September 29, 2017.

7) You provided a copy of the letter from Medical Assistance Program Vanguard Direct, dated September 29, 2017. The letter states your Medicaid coverage was being discontinued because it was determined you were already receiving Medicaid with NYSOH through account number [redacted] (*see* Appellant's Exhibit 1, p. 2).

8) You submitted an application to NYSOH for financial assistance on October 10, 2017.

9) According to your NYSOH account and your testimony, you were determined eligible for and enrolled in an Essential Plan on October 10, 2017.

10) You testified that you wanted your enrollment in your Essential Plan to begin on October 1, 2017, and not November 1, 2017.

11) You reside in Kings County, NY.

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

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)).

Legal Analysis

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

You were originally determined eligible for Medicaid effective June 1, 2016. Your eligibility ended effective May 31, 2017, as NYSOH received information you were already receiving Medicaid coverage through your local district.

You testified you were receiving Medicaid coverage through your local Human Resources Administration in Kings County. However, you were not aware your coverage through Medicaid in your local district was ending September 30, 2017, until your received a letter from that agency dated September 29, 2017 as reflected in the copy you provided in Appellant's Exhibit 1 at p. 2.

Please note it is not within the authority of the NYSOH Appeals Unit to review notices or the proper issuance of notices from local agencies administering benefits under Non-MAGI based Medicaid. Therefore, it cannot be determined whether proper notice was provided to you of the end date of your Medicaid coverage by the Human Resources Administration of Kings County. Any issues regarding lack of notice that your Medicaid coverage through your local district was ending properly belong before NYS Office of Temporary and Disability Assistance (OTDA). You can learn more about the fair hearing process before OTDA's Office of Administrative Hearings at https://otda.ny.gov.

You testified, and the record indicates, that you submitted your NYSOH application on October 10, 2017, were found eligible for the Essential Plan, and enrolled into a plan that day with an enrollment start date of November 1, 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 October 10, 2017, you selected an Essential Plan, so your enrollment properly took effect on the first day of the next month following October; that is, on November 1, 2017.

Therefore, the October 11, 2017 plan enrollment notice confirming that your enrollment in the Essential Plan you selected was effective November 1, 2017, is correct and must be AFFIRMED.

Decision

The October 11, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: December 26, 2017

How this Decision Affects Your Eligibility

The effective date of your Essential Health Plan is November 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 October 11, 2017 plan enrollment notice is AFFIRMED.

The effective date of your Essential Health Plan is November 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)

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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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