



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

## Notice of Decision

Decision Date: February 1, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024468

[REDACTED]

Dear [REDACTED],

On January 29, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 17, 2017 enrollment confirmation notice and November 18, 2017 disenrollment 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.

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## Decision

Decision Date: February 1, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024468

[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 2 with a \$0.00 premium ended as of November 30, 2017 and that your enrollment in an Essential Plan 1 with a \$20.00 premium was effective December 1, 2017?

## Procedural History

On November 17, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for the Essential Plan with a \$0.00 monthly premium, effective January 1, 2017.

Also on November 17, 2016, NYSOH issued an enrollment notice stating that you were enrolled in an Essential Plan 2 with a \$0.00 premium with a plan enrollment start date of January 1, 2017.

On October 28, 2017, NYSOH issued a renewal notice stating that you qualified for Medicaid, effective January 1, 2018, and that you were no longer eligible for the Essential Plan as of December 31, 2017. This notice directed you to make any changes to your account between November 16, 2017 and December 15, 2017 in order for these changes to be effective January 1, 2018.

On November 16, 2017, you updated your application for financial assistance. That day, NYSOH issued a preliminary eligibility determination based on that

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application, stating that you were eligible for the Essential Plan 1 with a \$20.00 premium, effective December 1, 2017.

Also on November 16, 2017, you submitted a second application for financial assistance. That day, NYSOH issued a second preliminary eligibility determination stating that you were eligible for the Essential Plan 2 with a \$0.00 premium, effective January 1, 2018.

Additionally, on November 16, 2017 you spoke to NYSOH's Account Review Unit and appealed the end date of your enrollment in your Essential Plan 2 with a \$0.00 premium as of November 30, 2017 and your enrollment in an Essential Plan 1 with a \$20.00 premium for the month of December 2017.

On November 17, 2017, NYSOH issued a notice of eligibility determination, based on the final application submitted on November 16, 2017, stating that you were eligible to enroll in the Essential Plan 2 with a \$0.00 premium, effective January 1, 2018.

Also on November 17, 2017, NYSOH issued a notice of enrollment stating that you were enrolled in an Essential Plan 2 with a \$0.00 premium, and that your plan would start January 1, 2018.

On November 18, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Essential Plan 2 with a \$0.00 premium would end on December 31, 2017. This was because you were no longer eligible to enroll in the Essential Plan 2.

On January 29, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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 were determined eligible for the Essential Plan 2 with a \$0.00 premium on November 16, 2016, with an effective date of January 1, 2017.
- 2) You testified that you received the October 28, 2017 renewal notice, which stated that you were eligible for Medicaid.
- 3) You testified that on November 16, 2017, you contacted NYSOH in order to submit your renewal for coverage for 2018.

- 4) You submitted two applications for financial assistance on November 16, 2017. You testified that one of those applications was meant to be for 2017 and included information regarding your income for 2017, and one of those applications was meant to be for 2018 and included information regarding your projected income for 2018.
- 5) You testified that you expect your income to be \$17,958.00 for 2018 and that your income for 2017 was \$17,356.00. You explained that you worked less in 2017.
- 6) Your NYSOH account reflects that you were enrolled in an Essential Plan 1 with a \$20.00 premium for the month of December 2017.
- 7) You testified that you are seeking to be enrolled in the Essential Plan 2 with a \$0.00 monthly premium for the month of December 2017.

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

## **Applicable Law and Regulations**

### Essential Plan Renewal

In general, NYSOH will review Essential Plan eligibility no more frequently than once every 12 months from the effective date of eligibility as long as enrollees are under age 65, not enrolled in minimum essential coverage, remain state residents, and do not have any changes in circumstances. An individual enrolled in the Essential Plan shall have his or her coverage continued until the end of the 12 month period, provided he or she does not lose eligibility by reason of citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage, failure to make the applicable premium payment, or changes in circumstances (42 CFR § 600.340(a); 42 CFR § 600.320(d); NY Social Services Law § 369-gg(3) and (4)(d)); New York's Basic Health Plan Blueprint, pp. 8 and 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>).

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 (42 CFR § 600.340(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 (42 CFR §600.345; (NY Social Services Law § 369-gg(4)(c); 45 CFR § 155.335(g); New York's Basic

Health Plan Blueprint, p. 17, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf>).

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/downloads/ny-blueprint.pdf>).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month (45 CFR § 155.420(b)(1)(i); see also 42 CFR § 600.320(c)). For updates 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 § 155.420(b)(1)(ii); see also 42 CFR § 600.320(c)).

## Legal Analysis

The issue under review is whether NYSOH properly determined that your enrollment in an Essential Plan 2 with a \$0.00 premium ended as of November 30, 2017 and that you were enrolled in an Essential Plan 1 with a \$20.00 premium effective December 1, 2017.

You testified, and the record indicates, that you updated your NYSOH application twice on November 16, 2017. As a result of that first application, you were found eligible for the Essential Plan 1 with a \$20.00 premium as of December 1, 2017. As a result of the second application, you were found eligible for the Essential Plan 2 with a \$0.00 premium as of January 1, 2018. You selected an Essential Plan 2 for enrollment that day.

Any changes in eligibility to the Essential Plan made between the first day to and including the fifteenth day of a month are to be made effective the first day of the following month. Any changes in eligibility to the Essential Plan made between the sixteenth day of the month to the end of the month are to be made effective the first day of the second following month.

As you updated your application on November 16, 2017, any changes to your eligibility should have taken effect on the first day of the second month following November 2017; that is, on January 1, 2018.

Therefore, the November 18, 2017 disenrollment notice stating that you were disenrolled from your Essential Plan 2 effective December 31, 2017 and the November 17, 2017 enrollment confirmation notice stating that your reenrollment

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in the Essential Plan 2 was effective January 1, 2018, are correct and must be AFFIRMED.

Your case is RETURNED to NYSOH to reinstate you into your Essential Plan 2 with a \$0.00 premium, from December 1, 2017 through December 31, 2017.

## **Decision**

The November 17, 2017 enrollment confirmation notice is AFFIRMED.

The November 18, 2017 disenrollment notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate you into your Essential Plan 2 with a \$0.00 premium from December 1, 2017 through December 31, 2017.

**Effective Date of this Decision:** February 1, 2018

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

You should have remained in the Essential Plan 2 with a \$0.00 premium for the month of December 2017.

Your case is being sent back to NYSOH to reinstate you into your Essential Plan 2 with a \$0.00 premium for the month of December 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)).

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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 November 17, 2017 enrollment confirmation notice is **AFFIRMED**.

The November 18, 2017 disenrollment notice is **AFFIRMED**.

Your case is **RETURNED** to NYSOH to reinstate you into your Essential Plan 2 with a \$0.00 premium from December 1, 2017 through December 31, 2017.

You should have remained in the Essential Plan 2 with a \$0.00 premium for the month of December 2017.

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).



Your case is being sent back to NYSOH to reinstate you into your Essential Plan 2 with a \$0.00 premium for the month of December 2017.

### **Legal Authority**

We are issuing this determination in accordance with 45 CFR § 155.545.

**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 1-855-355-5777 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 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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