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

Notice of Decision

Decision Date: April 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014334

[redacted]

Dear [redacted],

On March 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 23, 2016 eligibility determination 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 NY State of Health 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 Date: April 19, 2017

NY State of Health Account ID: [redacted]
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Issues

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

> Did NY State of Health properly determine that you were eligible for the Essential Plan, effective February 1, 2017?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid as of the issuance of the December 23, 2016 notice?

Procedural History

On December 7, 2016 and on December 8, 2016 and in response to NYSOH's request, you submitted your proof of income, including your 2016 Social Security Benefit award statement, a long-term disability statement, and a letter from Social Security stating that your brother was no longer receiving benefits, which were subsequently invalidated on December 22, 2016 (*see* Documents: [redacted]).

On December 23, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan for a limited time, effective February 1, 2017. By that notice and another December 23, 2016 notice, NYSOH stated more proof of income was needed by March 22, 2017.

On December 27, 2016, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as your Essential Plan began on February 1, 2017 and not on January 1, 2017.

On December 28, 2016, NYSOH issued an enrollment confirmation notice, based on your December 27, 2016 plan selection, stating that you were enrolled in the Essential Plan with a premium of $47.30 per month, effective February 1, 2017.

On March 6, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you requested to amend your appeal to have your eligibility redetermined for Medicaid. The Hearing Officer granted the request and your appeal was amended on the record. The record was developed during the hearing and held open to March 21, 2016, to allow you to submit supporting documents.

As of March 21, 2016, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) According to your NYSOH account, you had health insurance coverage with Medicaid as of December 1, 2015, and were enrolled in a Medicaid Managed Care plan, effective January 1, 2016 through November 30, 2016.

2) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim one dependent on that tax return.

3) You are seeking insurance for yourself as of December 1, 2016.

4) The application that was submitted on December 6, 2016 listed annual household income of $21,936.00, consisting of $18,336.00 you receive in Social Security benefits and $3,600.00 you receive in Survivor's Benefits.

5) On December 7, 2016 and December 8, 2016, you submitted documentation as proof that your household income was $21,940.08, consisting of $18,336.00 in Social Security benefits and $3,604.08 in Survivor's Benefits. You testified that this information was correct.

6) According to your NYSOH account, NYSOH calculated your household income to be $25,540.08, based upon your 2016 Social Security Benefits Statement and by counting your Survivor's Benefits twice.

7) According to your NYSOH account, on December 22, 2016, NYSOH invalidated your proof of income because your Social Security Benefit

Statement, dated January 4, 2016, listing your 2016 benefits, was outdated and “not from the current calendar year.”

8) Your application states that you will not be taking any deductions on your 2016 tax return.

9) Your application states that you live in [redacted], New York.

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

Applicable Law and Regulations

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2015 FPL, which is $15,930 for a two-person household (80 Federal Register 3236, 3237.).

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 $ 16,020.00 for a two-person household (81 Fed. Reg. 4036).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Medicaid Managed Care (MMC) plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H(6)(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019, N.Y. Soc. Serv. Law §364-j(1)(c); 18 NYCRR § 360-10.3(h)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan and not Medicaid as your December 22, 2016 application for financial assistance.

In the application submitted on December 22, 2016, NYSOH updated your account, based on the income documentation you submitted, and calculated that your household income was $25,540.08. NYSOH then relied upon this income information in determined your eligibility for financial assistance.

However, it appears that NYSOH calculated your household income to be $25,540.08 by counting your Survivor's Benefits twice. The record reflects that you submitted documentation and credibly testified that your annual household income for 2016 is $21,940.08. Therefore, it is reasonable to conclude that NYSOH improperly determined your household income to be $25,540.08. It is further reasonable to conclude that, while it is unclear why NYSOH invalidated your 2016 Social Security Benefits Statement, your benefits were accurate for the entire year and not outdated as of your December 22, 2016 applications Therefore, the correct household income as of your December 22, 2016 application was $21,940.08.

You are in a two-person household for purposes of this analysis. This is because you expect to file your 2016 income taxes as head of household and will claim one dependent on that tax return.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $15,930.00 for a two-person

household. Since an annual household income of $21,490.08 is 134.9% of the 2015 FPL, NYSOH improperly found you to be eligible for the Essential Plan.

Since the December 22, 2016 preliminary eligibility determination relied upon a household income that NYSOH miscalculated and the December 23, 2016 notice improperly stated that, based on this misinformation, you were conditionally eligible for the Essential Plan and ineligible for Medicaid, the December 23, 2016 eligibility determination notice is incorrect and must be RESCINDED.

It necessarily follows that the December 28, 2016 enrollment confirmation notice is incorrect and must be RESCINDED.

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month. The record reflects that your applications were submitted on December 6, 2016 and December 22, 2016 respectively and your Medicaid Managed Care enrollment ended as of November 30, 2016. Since the record now contains a more accurate representation of what your annual income was for 2016, your case is RETURNED to NYSOH to redetermine your eligibility for and coverage with Medicaid as of December 1, 2016, based on a household size of two people and an annual 2016 household income of $21,940.08.

Decision

The December 23, 2016 eligibility determination notice is RESCINDED.

The December 28, 2016 enrollment confirmation notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for and coverage with Medicaid as of December 1, 2016, based on a household size of two people and an annual 2016 household income of $21,940.08, and to notify you accordingly.

Effective Date of this Decision: April 19, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. Your case is being sent back to NYSOH to redetermine your eligibility for Medicaid as of December 1, 2016, based on the evidence adduced at the hearing.

NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

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 December 23, 2016 eligibility determination notice is RESCINDED.

The December 28, 2016 enrollment confirmation notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for and coverage with Medicaid as of December 1, 2016, based on a household size of two people and an annual 2016 household income of $21,940.08, and to notify you accordingly.

This is not a final determination of your eligibility. Your case is being sent back to NYSOH to redetermine your eligibility for Medicaid as of December 1, 2016, based on the evidence adduced at the hearing.

NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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)

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।

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).

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 नि:शुल्क 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.

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).