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

Notice of Decision

Decision Date: May 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014392

[redacted]

Dear [redacted],

On April 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 3, 2016 eligibility determination, November 24, 2016 plan enrollment and December 17, 2016 eligibility determination notices.

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

Decision

Decision Date: May 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014392

[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 you were eligible for the Essential Plan, effective January 1, 2017?
>
> Did NY State of Health properly determine that your enrollment in an Essential Plan was effective January 1, 2017?

Procedural History

On October 24, 2016, in response to NYSOH's request, you submitted proof of your income, including six weekly paystubs dated through October 19, 2016 (*see* Documents [redacted]).

This documents were validated by NYSOH on November 2, 2016

On November 6, 2016, November 13, 2016, and November 21, 2016, in response to NYSOH's request, you submitted additional proof of your income, including four additional weekly consecutive paystubs dated through November 16, 2016, which were subsequently validated by NYSOH on November 21, 2016.

On November 24, 2016, NYSOH issued an eligibility determination notice stating that, based on your November 23, 2016 updated application in which your income was reported as $21,307.52, you were eligible for the Essential Plan for a limited time with a monthly premium of $20.00, effective January 1, 2017. The

notice also instructed you to provide proof of income by February 21, 2017 to confirm your eligibility.

Also on November 24, 2016, NYSOH issued a plan enrollment notice, based on your November 23, 2016 plan selection, confirming your enrollment in the Essential Plan, effective January 1, 2017.

On December 16, 2016, in response to NYSOH's request, you submitted additional proof of your income, including a letter from your employer stating you are a seasonal employee and that your year-to-date gross earnings were $18,456.56.

On December 17, 2016, NYSOH issued another eligibility determination notice stating that you were eligible to enroll in the Essential Plan for a limited time, effective January 1, 2017.

Also on December 17, 2016, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan with a monthly premium of $20.00, effective January 1, 2017.

On December 28, 2016, you spoke to NYSOH's Account Review Unit and appealed your eligibility determination insofar as your coverage in the Essential Plan began as of January 1, 2017 and not December 1, 2016.

On January 9, 2017, NYSOH validated your proof of income as submitted on December 16, 2016.

On January 10, 2017, NYSOH issued an eligibility determination notice stating that you were fully eligible for the Essential Plan with a premium of $20.00, effective February 1, 2017.

Also on January 10, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan, effective January 1, 2017.

On March 20, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you requested to amend the appeal to include a redetermination of your eligibility for the month of December 2016. The request was granted and the record was held open until April 5, 2017 for you to provide proof of income and proof of deductions.

On April 4, 2017, you submitted your only two paystubs for the month of December 2016 along with a letter from your employer stating that your last paystub was issued December 14, 2016. These documents were made part of the record as "Appellant's Exhibit A." No further documentation was received by April 5, 2017. The record is now closed.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

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

3) The application that was submitted on October 23, 2016 listed annual household income of $11,501.45 in earnings from your employment. The income you attested to did not match federal and state data sources.

4) On October 24, 2016, you submitted six paystubs from your employer, including one paystub dated August 31, 2016 and five consecutive paystubs dated September 21, 2016 through October 19, 2016 indicating that your income varied from $159.65 per week to $1,597.90 per week. These paystubs also show that your year-to-date income for 2016 as of October 19, 2016 was $12,545.41 ([redacted]

5) The application that was submitted on December 16, 2016 listed an annual household income of $19,457.56 in earnings from your employment.

6) Your application states that you will be taking deductions on your 2016 tax return. You testified this was correct, but you were unsure of what the amount. The record was held open until April 5, 2017 for you to submit proof of your deductions. You did not provide any proof of deductions as of that date.

7) You testified that you submitted proof of income on multiple occasions and that you were receiving multiple notices from NYSOH as to your eligibility at the same time, which you found confusing.

8) According to your NYSOH, on November 23, 2016, you were redetermined conditionally eligible for the Essential Plan, effective January 1, 2017, based on a listed household income at that time of $21,307.52.

9) According to your NYSOH account, you submitted a letter from your employer dated December 15, 2016 stating that you were a seasonal employee and that your year-to-date 2016 gross earnings were $18,456.56. This letter was validated by NYSOH on January 9, 2017 and you were found fully eligible for the Essential Plan as of that date.

10) You testified that you only worked until December 3, 2016 because you were in the hospital and, therefore, only received one paystub for that month. During the hearing, you requested to amend the appeal to include a redetermination for Medicaid that month. The request was granted and the record held open until April 5, 2017 for you to provide proof of income for December 2016 and proof of deductions.

11) On April 4, 2017, you submitted your only two paystubs for the month of December 2016, along with a letter from your employer stating that your last paystub was issued December 14, 2016. These documents reflect that you earned $1,869.01 in December 2016 and that your 2016 annual gross income from this employer was $18,458.46.

12) You testified that you wanted your enrollment in an Essential Plan to begin on December 1, 2016 or to be determined eligible for Medicaid that month because you were in the hospital and have outstanding medical expenses related to your hospitalization.

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 $11,770.00 for a one-person household (80 Federal Register 3236, 3237).

De Novo Review

The Marketplace Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

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).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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 found you eligible for the Essential Plan and ineligible for Medicaid as of December 16, 2016.

According to your NYSOH account, you are single and have no dependents. Therefore, you are in a one-person household for purposes of this analyses.

Your December 16, 2016 application states that you had a household income of $19,457.56 and NYSOH relied on that information.

The Essential Plan is provided through NYSOH to individuals who meet the nonfinancial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% of the FPL for the applicable family size. The applicable FPL at the time of your December 16, 2016 application was $11,770.00 for a one-person household. Since a household income of $19,457.56 is 165.31% of the applicable FPL for a one-person household, NYSOH properly found you to be eligible for the Essential Plan, effective January 1, 2 017, using the information provided in your application.

Therefore, the December 17, 2016 eligibility determination notice that stated, based on the information you provided on your December 16, 2016 application, you were conditionally eligible for the Essential Plan is correct and must be AFFIRMED.

Further, you requested to amend your appeal at the hearing to include being reconsidered for Medicaid based on your December 2016 monthly income, which the Hearing Officer granted.

The record does not contain a notice of eligibility determination or redetermination on the issue of your request for Medicaid. It does contain a December 29, 2016 notice that acknowledges you as the appellant and identifying the issue on appeal as “Eligibility Determination.” In addition, the Hearing Officer received testimony that you would like to be redetermined eligible for Medicaid.

Here, the lack of a notice of eligibility determination on the issue of Medicaid eligibility does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH’s failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The record, including the December 29, 2016 notice, along with your testimony, demonstrates that you did request an appeal on your eligibility determination as it relates to your eligibility for financial assistance in December 2016, including that of Medicaid. Therefore, it is reasonable to conclude that the totality of the evidence constitutes

an appeal on the issue of your eligibility for Medicaid and permits an inference that NYSOH did deny your request to be determined eligible for Medicaid.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to any notice of eligibility determination had it been issued. Therefore, the second issue under review is refined to whether NYSOH properly found you ineligible for Medicaid as of December 1, 2016.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since $19,457.56 is 163.78% of the 2016 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You testified that you only worked until December 3, 2016 because you were in the hospital and, therefore, only received 1 paystub for that month. You further testified that you take deductions from your income. However, proof of your deductions was never submitted and, as such, there is nothing in evidence to be considered in this regard. The documentation that you did submit on April 4, 2017, reflects that you had two paystubs in the month of December 2016, totaling $1,869.01. Therefore, for purposes of this analysis, your income for December 2016 is $1,869.01.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have a monthly income no greater than 138% of the FPL, which is $1,367.00 per month. There is nothing in the record to suggest you do not meet the non-financial criteria, so the analysis turns to the financial criteria. Since your monthly income of $1,869.01 is greater than the maximum monthly income limit of $1,367.00 for a one-person household, you do not qualify for Medicaid based on monthly income as of the date of your application.

By this Decision, you were not eligible for Medicaid as of December 1, 2016.

The sole remaining issue under review is whether NYSOH properly redetermined that your enrollment in an Essential Plan was effective January 1, 2017.

Generally, the date on which the Essential Plan can take effect depends on the day a person selects the plan for enrollment. In your case, you selected an

Essential Plan on November 23, 2016, the same day you were determined conditionally eligible for that program.

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 after the fifteenth day of a month goes into effect on the first day of the second following month.

Since you selected an Essential Plan on November 23, 2016, it must take effect on the first day of the second month following November 2016; that is, on January 1, 2017.

Therefore, the November 24, 2016 as well as the December 17, 2016 plan enrollment notices stating that your Essential Plan enrollment start date was January 1, 2017 are AFFIRMED.

Decision

The December 17, 2016 eligibility determination is AFFIRMED.

The November 24, 2016 and December 17, 2016 plan enrollment notices are AFFIRMED.

Effective Date of this Decision: May 16, 2017

How this Decision Affects Your Eligibility

You were eligible for and enrolled in the Essential Plan, effective January 1, 2017.

By this Decision, you were not eligible for Medicaid as of December 1, 2016.

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 17, 2016 eligibility determination is AFFIRMED.

The November 24, 2016 and December 17, 2016 plan enrollment notices are AFFIRMED.

You were eligible for and enrolled in the Essential Plan, effective January 1, 2017.

By this Decision, you were not eligible for Medicaid as of December 1, 2016.

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 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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