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

Notice of Decision

Decision Date: May 04, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014917

[redacted]

Dear [redacted],

On April 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 12, 2017 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 04, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014917

[redacted]

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 you were eligible for the Essential Plan, and not Medicaid, effective February 1, 2017?

Procedural History

On January 5, 2017, in response to NYSOH's request, you submitted proof of your income, including four weekly consecutive paystubs dated through December 30, 2016 and a letter stating that your hours vary. These documents were validated by NYSOH on January 11, 2017.

On January 12, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a premium of $20.00 per month, effective February 1, 2017.

On January 13, 2017, NYSOH issued a plan enrollment notice, based on your January 12, 2017 plan selection, confirming that you were enrolled in the Essential Plan with a premium of $47.60 per month, effective February 1, 2017.

On January 18, 2017, you spoke to NYSOH's Account Review Unit and appealed your eligibility insofar as you were found eligible for the Essential Plan and not eligible for Medicaid.

On April 7, 2017, 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 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 January 1, 2017.

3) The application that was submitted on January 5, 2017 listed annual household income of $14,796.08, consisting of $14,796.08 you earn from your employment.

4) On January 5, 2017, you submitted four consecutive paystubs from your employer, including a paystub dated December 30, 2016 indicating that your income for 2016 was $14,976.08 and a letter of attestation stating that your hours vary [redacted]. You testified that this information was correct.

5) You testified that your income from this employer is your sole source of income and that your weekly income varies because you do not get paid for time off, including holidays and school breaks. You expect your income in 2017 to be the same as it was in 2016.

6) According to your NYSOH account, NYSOH calculated your household income to be $19,541.99, based upon an average of the four weekly paystubs you submitted.

7) Your application states that you will not be taking any deductions on your 2017 tax return.

8) Your application states that you live in Bronx County, 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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036.).

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).

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, effective February 1, 2017.

Based on the income documentation you submitted, on January 11, 2017, NYSOH updated your account and calculated that your household income was $19,541.99. NYSOH then relied upon this income information in determining your eligibility for financial assistance.

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2016 income taxes as single and will claim no dependents 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 $11,880.00 for a one-person household. Since an annual household income of $19,541.99 is 164.49% of the 2016 FPL, NYSOH found you to be eligible for the Essential Plan.

However, it appears that NYSOH improperly determined your household income to be $19,541.99 by averaging the four consecutive paystubs you submitted without considering your attestation that your income varies. When considering these two components together, along with your attested annual income, your documentation and credible testimony reflect that your annual household income for 2017 is expected to be $14,976.08. Based on the totality of this evidence, it is reasonable to conclude that NYSOH improperly determined your household income to be $19,541.99, when the correct household income as of your January 11, 2017 application should have been $14,976.08.

Using the same requirements stated above, on the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $14,976.08 is 126.06% of the 2016 FPL, NYSOH improperly found you to be eligible for the Essential Plan.

Since the January 11, 2017 eligibility determination relied upon a household income that NYSOH miscalculated and the January 12, 2017 eligibility determination notice improperly stated that, based on this misinformation, you were eligible for the Essential Plan and ineligible for Medicaid, the January 12, 2017 eligibility determination notice is incorrect and must be RESCINDED.

It necessarily follows that the January 13, 2017 enrollment confirmation notice is incorrect and must also 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 January 5, 2017 and January 11, 2017 respectively. Since the record now contains a more accurate representation of what your annual income will be for 2017, your case is RETURNED to NYSOH to redetermine your eligibility for and coverage with Medicaid as of January 1, 2017, based on a household size of one person and an annual 2017 household income of $14,976.08.

Decision

The January 12, 2017 eligibility determination notice is RESCINDED.

The January 13, 2017 enrollment confirmation notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for Medicaid eligibility and coverage as of January 1, 2017, based on a household size of one person and an annual 2017 household income of $14,976.08, and to notify you accordingly.

Effective Date of this Decision: May 04, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility for Medicaid as of January 1, 2017, based on the evidence you presented 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 January 12, 2017 eligibility determination notice is RESCINDED.

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).

The January 13, 2017 enrollment confirmation notice is RESCINDED.

Your case is RETURNED to NYSOH to consider your request for Medicaid eligibility and coverage as of January 1, 2017, based on a household size of one person and an annual 2017 household income of $14,976.08, and to notify you accordingly.

This is not a final determination of your eligibility. Your case is sent back to NYSOH to redetermine your eligibility for Medicaid as of January 1, 2017, based on the evidence you presented 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:

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।

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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 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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