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

Notice of Decision

Decision Date: July 13, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000015897

Dear

On May 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 27, 2016 eligibility determination notice, December 29, 2016 eligibility determination notice, and March 17, 2017 eligibility and enrollment confirmation 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.

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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).

nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: July 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015897

Issues

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

> Did NY State of Health (NYSOH) properly determine you were eligible to purchase a full cost qualified health plan, effective February 1, 2017, and not eligible for Medicaid or other financial assistance?
>
> Did NYSOH) properly determine you were eligible to receive up to $91.00 per month in advance payments of the premium tax credit, effective February 1, 2017?
>
> Did NY State of Health properly determine you were eligible to enroll in the Essential Plan, for a limited time, effective May 1, 2017?

Procedural History

On November 30, 2016, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance.

On December 1, 2016, NYSOH issued a notice stating the income information in your application did not match the information obtained from state and federal data sources. The notice directed you to submit proof of your income by December 15, 2016 to confirm the information in your application or you might lose your insurance or receive less help paying for your coverage.

You submitted income documentation on or before December 13, 2016.

On December 27, 2016, NYSOH issued an eligibility determination notice, based on a December 26, 2016 systematic eligibility redetermination, stating you were newly eligible to purchase a qualified health plan at full cost, effective February 1, 2017. The notice indicated that you were not eligible to receive financial assistance because NYSOH had not received the requested income documentation necessary to verify the income information listed in your application.

On December 28, 2016, NYSOH verified the income documentation you submitted. The same day your eligibility was systematically redetermined.

On December 29, 2016, NYSOH issued an eligibility determination notice, based on the December 28, 2016 systematic eligibility redetermination, stating you were eligible to receive advance payments of the premium tax credit (APTC) of up to $91.00 monthly, effective February 1, 2017. The notice indicated you were not eligible for cost-sharing reductions, Medicaid, or the Essential Plan, because your household income of $44,888.53 was over the allowable income limit for those programs.

On February 2, 2017, NYSOH received your written request for an appeal of that eligibility determination insofar as you were not eligible for a greater level of financial assistance.

On May 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents.

On June 8, 2017, NYSOH received your documentation and it was incorporated into the record as Appellant's Exhibit [redacted] and the record closed thereafter.

Findings of Fact

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

1) You were determined eligible for Medicaid, effective January 1, 2016, based on a 2014 Form 1040 you submitted showing you had $15,995 in gross business income in 2014 and an adjusted gross income of $4,681.00. The income documentation you submitted verified the income information listed in your application and you were determined full eligible for Medicaid.

2) On November 30, 2016, you updated your application to renew your coverage for the 2017 coverage year. That application listed your annual income at $12,000.00 consisting of $1,000.00 earned monthly from your business.

3) According to your account, NYSOH was unable to verify the income information listed in your application and income documentation was requested by December 15, 2016, so that NYSOH could determine your eligibility for financial assistance with health insurance.

4) The December 1, 2016 notice directing you to submit income documentation included a list of acceptable documentation for various types of income. The notice indicated that acceptable documentation for self-employment income included records of detailed earnings and expenses or business payrolls and records for the last three months, or a signed and dated filed tax return from the previous year if representative of attested income.

5) On December 13, 2016, NYSOH received a copy your 2015 tax return showing adjusted gross income of $32,888.00 ( ). There was no earned income listed on this tax return.

6) The 2015 tax return included two Form 1099Rs showing disbursements to as Administrator of the Estate of in the amount of $32,888.53 from the NYS and Local Employees Retirement System ( ). The distributions were " No further explanation for these funds is included in the documentation.

7) Applications you submitted on February 12, 2015 and December 9, 2015, indicated your anticipated annual income would be $17,400.00 and $16,000.00, in earned income. The income you purportedly received from was not listed. It is not clear why this earned income was not included on your tax return for 2015.

8) The December 27, 2016 eligibility determination finding you ineligible for financial assistance because NYSOH had purportedly not received the requested income documentation by the December 15, 2016 deadline, was issued one day prior to NYSOH verifying the income documentation previously received on December 13, 2016.

9) According to your account, your income documentation was verified by NYSOH on December 28, 2016 and your application was systematically updated by adding the $32,888.53 in disbursements from the 2015 Form 1099s you provided to your attested business income of $12,000.00 for a total household income of $44,888.53.

10) As a result of the December 28, 2016 systematically updated application, NYSOH determined you were eligible to receive up to $91.00 in APTC,

effective February 1, 2017, and ineligible for Medicaid or the Essential Plan.

11) You were disenrolled from your Medicaid Managed Care plan, effective December 31, 2016.

12) You testified the 2015 tax return you submitted as proof of your income, was not indicative of your income in 2016 or 2017. You testified you received from at the end of 2014 and it was reported on your 2015 tax return. You testified the only income you received in 2016 was income from your part-time seasonal business.

13) You testified your adjusted gross income for 2016 was $17,500.00 and you expect your income in 2017 to be the same.

14) According to your account, you updated your application twice on March 16, 2017. The final application listed your annual income as $17,160.00 consisting of $330.00 in weekly unemployment insurance benefits.

15) Based on the information in that application, NYSOH determined you conditionally eligible to enroll in the Essential Plan, effective May 1, 2017. You were directed to submit documentation to confirm the income information listed in your application by June 14, 2017.

16) Your account confirms, you selected an Essential Plan for enrollment on March 16, 2017 and your coverage through this plan became effective on May 1, 2017.

17) You testified, and your account confirms, you did not have health coverage for the months of January 2017 through April 2017. You testified you have outstanding medical bills from those months.

18) On May 22, 2017, you uploaded several documents including a written letter requesting your health coverage be reinstated for the months of January 2017 through April 2017 and outstanding medical bills from those months.

19) You testified you are seeking reinstatement of your Medicaid coverage for the months of January 2017 through April 2017 or you are seeking to have coverage through your Essential Plan backdated to January 1, 2017.

20) During the hearing, you were directed to submit business records for the months of November and December 2016 to prove your income for those months.

21) On June 8, 2017, NYSOH received a letter from your accountant dated June 7, 2017 stating that you earned $930.00 in November 2016 and $800.00 in December 2016 ( ). There is no indication if this income was from self-employment or otherwise.

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

23) You testified, and your applications indicate, you will not be taking any deductions on your 2017 tax return.

24) You testified, and your applications indicate, that you live in

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

Applicable Law and Regulations

Verification Process

For individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR § 155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR § 155.315(f)).

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)).

<u>Medicaid</u>

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).

Legal Analysis

The first issue is whether NYSOH properly determined you were eligible to purchase a full cost qualified health plan, effective February 1, 2017.

The updated application you submitted on November 30, 2016 listed your annual income as $12,000.00 consisting of self-employment income. According to your account, NYSOH was unable to verify the income information listed in that application.

Pursuant to the above cited regulations, for all individuals whose income is needed to calculate the household’s eligibility, the Marketplace must request data that will allow the Marketplace to verify the household’s income. If the Marketplace cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

In the notice dated December 1, 2016, NYSOH notified you that the income information listed in your application did not match the information obtained from data sources. That notice directed you to submit documentation confirming your income by December 15, 2016. That notice also included a list of acceptable documentation for various types of income. The notice indicated that acceptable documentation for self-employment income included records of detailed earnings and expenses or business payrolls and records for the last three months, or a

signed and dated filed tax return from the previous year if representative of attested income.

Your account confirms that on December 13, 2016, NYSOH received a copy your 2015 tax return, which you submitted as proof of your income showing adjusted gross income of $32,888.00. You testified that the 2015 tax return included an [redacted] you received in late 2014 from [redacted] and was not indicative of your income in 2016 or your expected income in 2017. However, the [redacted] that appear to relate to [redacted] total $32,888.53, which is approximately the total income you declared in 2015. There is nothing on your tax return that would indicate you received earned income in 2015, as you noted on your applications in 2015.

According to your account, this documentation, along with the corresponding 2015 Form 1099s, was the only income documentation you submitted in response to the December 1, 2016 notice requesting proof of current income. Accordingly, by your own testimony, the income documentation you submitted was not reliable.

Additionally, you testified that your adjusted gross income in 2016 was $17,500.00 which contradicted the $12,000.00 amount listed in your November 30, 2016 application. Therefore, the evidence establishes you failed to submit documentation sufficient to confirm the income information in your November 30, 2016 application by the December 15, 2016 deadline as provided in the December 1, 2016 notice.

Accordingly, the December 27, 2016 eligibility determination, stating you were eligible to purchase a full cost qualified health plan and ineligible for financial assistance, including Medicaid, because you failed to provide documentation verifying your income by the due date, is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly subsequently determined that you were eligible to receive up to $91.00 per month in advance payments of the premium tax credit, effective February 1, 2017.

As noted above, although your income documentation was verified by NYSOH on December 28, 2016, and was the basis of the December 29, 2016 eligibility determination notice finding you eligible to receive up to $91.00 of APTC, effective February 1, 2017, the record, as developed during the hearing, no longer supports that eligibility. Therefore, the December 29, 2016 notice of eligibility determination must be RESCINDED.

The third issue under review is whether NYSOH properly determined your coverage through your Essential Plan became effective no earlier than May 1, 2017.

You testified, and the record indicates, that an updated application was submitted on your behalf on March 16, 2017. As a result, you were found conditionally eligible for the Essential Plan, effective May 1, 2017, and you selected a plan for enrollment that day. Your Essential Plan coverage became effective May 1, 2017.

Pursuant to the regulations, 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.

Since you selected your Essential Plan on March 16, 2017, after the fifteenth day of the month, your enrollment properly took effect on the first day of the second following month; that is, on May 1, 2017.

Therefore, the March 17, 2017 enrollment confirmation notice stating your enrollment in the Essential Plan was effective May 1, 2017, is correct and must be AFFIRMED.

It is noted that NYSOH's request for income documentation to confirm the income information listed in your March 16, 2017 application remains outstanding. Accordingly, you are encouraged to submit sufficient documentation to avoid termination of your coverage.

Decision

The December 27, 2016 eligibility determination notice is AFFIRMED.

The December 28, 2016 eligibility determination notice is RESCINDED

The March 17, 2017 enrollment confirmation notice is AFFIRMED.

Effective Date of this Decision: July 13, 2017

How this Decision Affects Your Eligibility

You were not eligible to receive financial assistance as of January 1, 2017.

Your coverage through your Essential Plan did not become effective until May 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 December 27, 2016 eligibility determination notice is AFFIRMED.

The December 28, 2016 eligibility determination notice is RESCINDED

The March 17, 2017 enrollment confirmation notice is AFFIRMED.

You were not eligible to receive financial assistance as of January 1, 2017.

Your coverage through your Essential Plan properly did not become effective until May 1, 2017.

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)

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).

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.

(Urdu)اردو

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).

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