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

Notice of Decision

Decision Date: December 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022695

Dear [redacted]

On November 30, 2017, you and your authorized representative appeared by telephone at a hearing on your appeal of NY State of Health's August 26, 2017 eligibility determination and disenrollment notices, and September 30, 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 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: December 27, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000022695

Issues

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

> Did NY State of Health properly determine you were no longer eligible for the Essential Plan, effective October 1, 2017?
>
> Did NY State of Health properly determine you were next eligible for the Essential Plan effective November 1, 2017?
>
> Did NY State of Health properly determine you were ineligible for Medicaid, effective September 1, 2017?

Procedural History

On July 13, 2017, NY State of Health (NYSOH) received your application for financial assistance with your health insurance.

On July 14, 2017, NYSOH issued a notice stating more information was needed to make a determination. The notice explained the income documentation you provided NYSOH did not match what was obtained from state and federal data sources. You were directed to submit income documentation for your household by July 28, 2017.

No income documentation was received by the deadline of July 28, 2017.

On August 8, 2017, NYSOH issued a notice stating you were eligible to purchase a qualified health plan at full cost, effective September 1, 2017. The notice stated you did not qualify for financial assistance because NYSOH did not receive the income documentation needed to verify the income listed in your application.

On August 23, 2017, NYSOH issued an eligibility determination notice stating you were eligible to enroll in the Essential Plan with a $20.00 per month premium for a limited time, effective October 1, 2017. The notice directed you to provide proof of your income by November 20, 2017.

On August 23, 2017, you uploaded copies of your paystubs [redacted] [redacted].

On August 24, 2017, NYSOH issued an enrollment notice confirming your enrollment in the Essential Plan, effective October 1, 2017.

On August 25, 2017, NYSOH submitted an application for financial assistance on your behalf.

On August 26, 2017, NYSOH issued an eligibility determination notice based on that last application stating you were eligible for advance payments of the premium tax credit up to $46.00 per month, effective October 1, 2017.

On August 26, 2017, NYSOH issued a disenrollment notice stating your enrollment in the Essential Plan would end on October 1, 2017.

On September 19, 2017, NYSOH received your updated application for financial assistance. That day a preliminary eligibility determination was prepared finding you eligible for the Essential Plan for a cost of $20.00 per month for a limited time, effective November 1, 2017. The notice directed you to provide proof of your income by December 18, 2017. You enrolled in an Essential Plan that day for a November 1, 2017 enrollment start date.

Also on September 19, 2017, you contacted the NYSOH Account Review Unit and requested an appeal of the start date of your Essential Plan, requesting that it begin October 1, 2017.

On September 22, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan, effective November 1, 2017.

On September 30, 2017, NYSOH issued an eligibility determination notice stating you were eligible for the Essential Plan for a cost of $20.00 per month, effective November 1, 2017. The notice also stated you were not eligible for Medicaid

because your household income of $23,400.00 was over the allowable income limit for that program.

On November 30, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the call you appointed [redacted] as an authorized representative to represent you during the hearing. Your authorized representative amended your appeal to include that you were also appealing your eligibility for the Essential Plan and requesting it be redetermined for Medicaid. The record was developed during the hearing and kept open for 15 days for you to provide supporting income documentation.

On December 8, 2017, NYSOH's Appeals Unit received your supporting documentation in the form of a two-page fax, which was made part of the record as Appellant's Exhibit 1. The record was closed that day.

Findings of Fact

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

1) According to your authorized representative's testimony, you are appealing your enrollment start date of your Essential Plan and are seeking your eligibility be redetermined for Medicaid.

2) According to your NYSOH account, NYSOH received your application for financial assistance on August 23, 2017.

3) Your application of that date states your annual household income for 2017 would be $20,952.35.

4) Your application states you will be filing your 2017 taxes as single and will claim no dependents on that return.

5) On August 23, 2017, you provided proof of your income in the form of paystubs with check dates of July 28, August 4, 11, and 18, 2017. The checks showed you received gross income amounts of $581.63, $509.06, $448.88, and $446.63 respectively ([redacted]

6) According to your NYSOH account, on August 25, 2017, a NYSOH representative reviewed your submitted income documentation and added [redacted] to your application as income in the amount of $21,788.56.

7) The additional income that was added to your application on August 25, 2017, increased your annual household income to $42,740.91.

8) Your authorized representative testified you work at different locations but only for [redacted].

9) You were disenrolled from your Essential Plan, effective October 1, 2017, as your income as calculated by NYSOH was over the limit for that program as determined in the August 26, 2017 eligibility determination notice.

10) Your application on September 19, 2017, states your annual household income would be $23,400.00.

11) You provided income documentation in the form of a letter from your employer, dated August 30, 2017, stating you earn $11.25 an hour for forty hours a week [redacted]

12) You were determined eligible for the Essential Plan on September 19, 2017, and effective November 1, 2017.

13) You provided copies of your paystubs dated September 8, 15, 22, and 29, 2017 in the gross amounts of $473.63, $532.69, $448.00, and $477.00 respectively [redacted]

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

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

The maximum amount of APTC that can be authorized equals:

1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

minus

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2) the taxpayer's expected contribution amount

(*see* 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is $11,880.00 for a one-person household (81 Federal Register 4036.).

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.).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax

credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

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 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

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).

Verification Process

For all 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), 42 CFR § 435.945).

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) 42 CFR § 435.952).

Legal Analysis

The first issue under review is whether NYSOH properly determined you were no longer eligible for the Essential Plan, effective October 1, 2017.

You updated your NYSOH account on August 23, 2017. The application submitted states you plan on filing your 2017 taxes as single and will claim no dependents on that return.

The application on August 23, 2017 states your annual household income for 2017 would be $20,952.35. The result of your application was an eligibility determination finding you eligible for the Essential Plan for a cost of $20.00 per month with an FPL of 176% for 2017, effective October 1, 2017. The determination was only conditional, however, and you were directed to provide income documentation by November 20, 2017. You were also enrolled in an Essential Plan that day for an October 1, 2017 start date.

You submitted income documentation in the form of paystubs on August 23, 2017. A NYSOH representative reviewed these paystubs and submitted an application on your behalf on August 25, 2017 which increased your annual household income from $20,952.35 to $42,740.91 and a FPL of 359.77%, effective October 1, 2017.

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. An annual household income of $42,740.91 is 359.77% of the 2016 FPL.

This increase in income meant you were now over the income limit for the Essential Plan and newly eligible for APTC. As a result, you were disenrolled from your Essential Plan effective October 1, 2017.

Your NYSOH account shows a NYSOH representative added to your application as additional income in the amount of $21,788.56. However, you testified and the record supports this was income documentation reflecting your current income from only and not an additional job not attested to previously. As such, it is reasonable to conclude that NYSOH miscalculated your income by doubling it.

Therefore, the August 26, 2017 eligibility determination notice stating you were eligible for APTC up to $46.00 per month, effective October 1, 2017, and no longer eligible for the Essential Plan was improper and is RESCINDED, as it incorrectly determined your eligibility based on an error in the miscalculation of the income documentation you provided.

It follows that the August 26, 2017 disenrollment notice stating your enrollment in the Essential Plan ends on October 1, 2017 is RESCINDED.

Your case is RETURNED to NYSOH to reinstate you in your Essential Plan for the month of October 2017.

The second issue under review is whether NYSOH properly determined you were next eligible for the Essential Plan, effective November 1, 2017.

You submitted income documentation on September 19, 2017, in the form of a letter from your employer dated August 30, 2017 stating you earn $11.25 an hour for forty hours a week
NYSOH reviewed this income documentation and submitted an application on your behalf with an annual household income of $23,400.00.

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 $23,400.00 is 196.97% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan, effective November 1, 2017.

The third issue under review is whether NYSOH properly determined you were ineligible for Medicaid, effective September 1, 2017.

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 that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since $23,400.00 is 194.03% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

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

You provided copies of your paystubs dated September 8, 15, 22, and 29, 2017 in the gross amounts of $473.63, $532.69, $448.00, and $477.00 respectively Therefore, during the month of September, you received $1,931.32 in gross earnings.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,387.00 per month. Since the documentation you provided shows that you received $1,931.32 in gross earnings in September 2017, you do not qualify for Medicaid based on monthly income that month.

Since the September 30, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan and ineligible for Medicaid, it is proper and is AFFIRMED.

Decision

The August 26, 2017 eligibility determination notice is RESCINDED.

The August 26, 2017 disenrollment notice is RESCINDED.

The September 30, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate you in your Essential Plan for the month of October 2017, and to notify you once this is completed. You will be responsible for any premium payments requested by your health plan for that month.

Effective Date of this Decision: December 27, 2017

How this Decision Affects Your Eligibility

Your enrollment in your Essential Plan is effective October 1, 2017.

You are eligible for the Essential Plan.

You are ineligible for Medicaid as of September 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 August 26, 2017 eligibility determination notice is RESCINDED.

The August 26, 2017 disenrollment notice is RESCINDED.

The September 30, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate you in your Essential Plan for the month of October 2017, and to notify you once this is completed. You will be responsible for any premium payments requested by your health plan for that month.

Your enrollment in your Essential Plan is effective October 1, 2017.

You are eligible for the Essential Plan.

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).

You are ineligible for Medicaid as of September 1, 2017.

Legal Authority

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

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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।

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.

(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).