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

# Notice of Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028446

[redacted]

Dear [redacted]

On May 3, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 6, 2018 eligibility determination notice and verbal denial of a special enrollment period.

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

# Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000028446

[redacted]

## Issues

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

> Did NY State of Health properly determine that you and your son were eligible to receive up to $559.00 per month in advance payments of the premium tax credit, effective March 1, 2018?
>
> Did NY State of Health properly determine that you and your son were ineligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you and your son were ineligible for the Essential Plan?
>
> Did NY State of Health properly determine that you and your son were ineligible for Medicaid?
>
> Did NY State of Health properly determine that you and your son do not qualify to enroll in a qualified health plan outside of the open enrollment period?

## Procedural History

On February 2, 2018, you applied for health insurance and financial assistance through NY State of Health (NYSOH) for yourself and your son.

On February 3, 2018, NYSOH issued a notice of eligibility determination stating that you and your son were eligible to receive up to $559.00 per month in

advance payments of the premium tax credit (APTC), effective March 1, 2018. The notice further stated that you and your son may qualify to enroll in coverage outside of the open enrollment period.

On February 5, 2018, you updated your household's application for financial assistance with health insurance, specifically, you removed your daughter from your account.

That day, a preliminary eligibility determination was prepared stating that you and your son were eligible to receive up to $559.00 per month APTC, effective March 1, 2018. You also attempted to enroll yourself and your son into a qualified health plan but were unable to select a plan for enrollment.

Also on February 5, 2018, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you and your son were not eligible for an increased amount of financial assistance and you and your son were not eligible to enroll in a health plan outside of the open enrollment period.

On February 6, 2018, NYSOH issued an eligibility determination notice stating that you and your son were eligible to receive up to $559.00 in APTC, effective March 1, 2018. That notice also stated that you and your son were not eligible for cost-sharing reductions, the Essential Plan, or Medicaid because your annual household income was over the allowable income limits for those programs. It further stated that you may qualify to enroll in coverage outside of the open enrollment period.

Also on February 6, 2018, NYSOH issued a notice to confirm your appeal request from the previous day. That notice stated that the reason for your appeal was "denial of SEP".

On February 27, 2018, your account was updated to indicate that you and your son had lost health insurance coverage as of January 31, 2018.

On February 28, 2018, NYSOH issued a notice of eligibility determination stating that you and your son were eligible to receive up to $559.00 in APTC, effective April 1, 2018. This notice stated that you and your son qualified to select a qualified health plan for enrollment until April 1, 2018.

On March 22, 2018, you updated your household's application for financial assistance with health insurance, specifically, you updated your household's income.

On March 23, 2018, NYSOH issued a notice of eligibility determination stating that you and your son were eligible to receive up to $680.00 per month in APTC and eligible for cost-sharing reductions if you and your son enrolled in a silver

level qualified health plan, both effective May 1, 2018. It further stated that you and your son may qualify to enroll in coverage outside of the open enrollment period.

On May 3, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until May 17, 2018, to allow you time to submit supporting documents.

On May 16, 2018, NYSOH received your supporting documents by fax. The documents were incorporated into the record as Appellant's [redacted] and the record was closed.

## Findings of Fact

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

1) You testified that you expect to file your tax return for 2018 with a tax filing status of married filing jointly. You will claim one dependent, your son, on that tax return.

2) You are seeking insurance for yourself and your son.

3) You testified that although you will be claiming your son as a dependent, he will be filing a tax return.

4) Your application reflects that your son was born [redacted] and is [redacted]

5) Your account reflects that your son resides with you.

6) The application that was submitted on February 5, 2018 listed annual household income of $51,781.62, consisting of $17,619.36 you earn from your employment, $25,740.00 your spouse receives in Social Security Disability Benefits, and $8,422.26 you son earns from his employment. You testified that this information was correct as of that time, as based on your 2017 earnings, however, your household income has since changed.

7) You testified that you have two jobs. You work for [redacted], and the income from this employer stays the same throughout [redacted], but the income from your second job varies from biweekly pay period to biweekly pay period.

8) You testified that your son lost his job in December 2017 and began working for a different employer shortly before the hearing. You testified

that your son did not receive any unemployment insurance benefits in 2018.

9) Your application states, and you confirmed, that you will not be taking any deductions on your 2018 tax return.

10) Your application states, and you confirmed, that you live in Suffolk County.

11) You submitted your spouse's Social Security Award letter which indicates that for 2018 his monthly Social Security Disability Benefit is $2,188.00.

12) You submitted two of your son's weekly paystubs; the first is for pay date May 4, 2018 for a gross pay amount of $296.67 and a gross year to date pay amount of $607.20; the second is for pay date May 11, 2018 for a gross pay amount of $268.18 and a gross year to date pay amount of $875.38.

13) You submitted seven of your biweekly paystubs from [redacted] the first is for pay date February 2, 2018 for a gross pay amount of $608.11; the second is for pay date February 18, 2018 for a gross pay amount of $612.80; the third is for pay date March 2, 2018 for a gross pay amount of $612.80; the fourth is for pay date March 16, 2018 for a gross pay amount of $598.73; the fifth is for pay date March 30, 2018 for a gross pay amount of $612.80; the sixth is for pay date April 13, 2018 for a gross pay amount of $608.11; the seventh is for pay date April 27, 2018 for a gross pay amount of $594.04.

14) You submitted six of your biweekly paystubs from your second employer; the first is for pay date February 20, 2018 for a gross pay amount of $303.60; the second is for pay date March 6, 2018 for a gross pay amount of $151.80; the third is for pay date March 20, 2018 for a gross pay amount of $303.60; the fourth is for pay date April 3, 2018 for a gross pay amount of $151.80; the fifth is for pay date April 17, 2018 for a gross pay amount of $227.70; the sixth is for pay date May 1, 2018 for a gross pay amount of $151.80.

15) You testified, and the NYSOH system reflects, that you and your son previously had coverage through the Essential Plan in another NYSOH account, which coverage ended on January 31, 2018.

16) You testified that you believe you were provided misinformation by NYSOH representatives which prevented you from being able to enroll yourself and your son in coverage.

17) During the hearing, you gave permission for the Hearing Officer to listen to recordings of phone calls you had with NYSOH.

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18) On February 5, 2018, you placed a phone call to NYSOH. A review of the recording of that phone call reveals that during that phone call, you were told that you and your son were found eligible for APTC. You stated that you wanted to go over plan options. The NYSOH representative advised you that you were unable to select a plan for enrollment for yourself and your son for 2018 because the system was registering that it was outside of open enrollment. The NYSOH representative transferred you to an Account Review Unit representative.

    During the phone call with the Account Review Unit representative, you advised that representative that you and your son had been enrolled in the Essential Plan under a different NYSOH account. The Account Review Unit representative advised you that you could not enroll yourself and your son in a qualified health plan for 2018, and that your only option was to file an appeal. No attempt was made to answer the special enrollment questions in the application.

19) On February 27, 2018, you contacted NYSOH to follow-up on the status of your appeal. A review of the recording of that phone call reveals that following statements you made regarding your previous coverage, the NYSOH representative assisted you in updating your application for health insurance, including answering the special enrollment questions. You were not sure of which plan you wanted to select at that time. You were advised that you and your son were eligible for a special enrollment period and that you would need to select a plan by April 1, 2018.

20) In the application submitted on February 27, 2018, you indicated that you and your son lost coverage as of January 31, 2018. As a result of this application, you and your son were found eligible for a special enrollment period until April 1, 2018.

21) On March 22, 2018, you contacted NYSOH to follow-up on the status of your appeal. You advised the Account Review Unit representative that there had been a change to your household income, and the Account Review Unit representative assisted you in updating your household's application for financial assistance. You and your son were again found eligible to enroll in a qualified health plan with APTC. You indicated that you wanted to select a qualified health plan for enrollment. The Account Review Unit representative advised you that you and your son did not qualify for a special enrollment period and were therefore unable to enroll in a qualified health plan. The Account Review Unit representative advised you that this would be addressed as part of your appeal.

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

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## Applicable Law and Regulations

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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*

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 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is $20,420.00 for a three-person household (82 Federal Register 8831).

For annual household income in the range of at least 250% but less than 300% of the 2017 FPL, the expected contribution is between 8.10% and 9.56% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return).

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Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

Cost-Sharing Reductions

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level qualified health plan (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

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 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 2017 FPL, which is $20,420.00for a three-person household (82 Fed. Reg. 8831).

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/downloads/ny-blueprint.pdf).

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 2018 FPL, which is $20,780.00 for a three-person household (83 Fed. Reg. 2642).

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).

Medicaid for Children

A child aged 19 or 20, whose primary residence is with their parents, is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 155% of the federal poverty level (FPL) for the applicable family size (NY Social Services Law § 366)(b)(7); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to specific limitations, all persons whom such individual expects to claim as a tax dependent (42 CFR §435.603(f)(1)).

In the case of an individual who expects to be claimed as a tax dependent by another taxpayer, the household is the household of the taxpayer claiming such individual as a tax dependent (42 CFR §435.603(f)(2)).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3)

Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

With regard to eligibility for financial assistance through the Marketplace, a tax filer's household income includes the MAGI of all the individuals in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.36B-1(e)(1); 42 CFR § 435.603(d)(1)). The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

A person is not required to file a tax return if their gross income is less than the sum of the exemption amount plus the basic standard deduction allowable for that person (26 USC § 6012(1)(A)). For the 2018 year, a dependent who had yearly gross earned income greater than $6,500.00 or gross unearned income greater than $1,050.00 would be required to file a tax return (see IRS Revenue Procedure 2017-58).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

<u>De Novo Review</u>

NYSOH 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).

<u>Enrollment in a Qualified Health Plan</u>

NYSOH must provide annual open enrollment periods during which time qualified individuals may enroll in a qualified health plan and enrollees may change qualified health plans (45 CFR § 155.410(a)(1)).

For the benefit year beginning on January 1, 2018, the national annual open enrollment period began on November 1, 2017 and extended through December 15, 2017 (45 CFR § 155.410(e)(3)). NY State extended this enrollment period through January 31, 2018 for applications processed through NYSOH (https://www.health.ny.gov/press/releases/2017/2017-09-07_open_enrollment_dates.htm).

The effective date of coverage by a qualified health 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)). 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)).

Special Enrollment Periods

After each open enrollment period ends, NYSOH provides special enrollment periods to qualified individuals. During a special enrollment period, a qualified individual may enroll in a qualified health plan, and an enrollee may change their enrollment to another plan. This is generally permitted when one of the following triggering events occur:

(1) The qualified individual or his or her dependent either:

(i) Loses minimum essential coverage.

(ii) Is enrolled in any non-calendar year group health plan or individual health insurance coverage, even if the qualified individual or his or her dependent has the option to renew such coverage.

(iii) Loses pregnancy-related coverage.

(iv) Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year.

(2)(i) The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.

(ii) the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

(3) The qualified individual, or his or her dependent, becomes newly eligible for enrollment in a qualified health plan because he or she gains citizenship, status as a national, or lawful present or is no longer incarcerated.

(4) The qualified individual's or his or her dependent's, enrollment or non-enrollment in a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of NYSOH, its instrumentalities, or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities.

(5) The enrollee or, his or her dependent adequately demonstrates to NYSOH that the qualified health plan in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) The enrollee or enrollee's dependent is newly eligible or ineligible for advance payments of the premium tax credit, or change in eligibility for cost-sharing reductions.

(7) The qualified individual or enrollee, or his or her dependent, gains access to new qualified health plan as a result of a permanent move and either—

(i) Had minimum essential coverage for one or more days during the 60 days preceding the date of the permanent move, or

(ii) Was living outside of the United States or in a United States territory at the time of the permanent move;

(8) The qualified individual or dependent who gains or maintains status as an Indian may enroll in a qualified health plan or change from one plan to another, once per month.

(9) The qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide;

(10) A qualified individual or enrollee—

(i) Is a victim of domestic abuse or spousal abandonment, including a dependent or unmarried victim within a household, is enrolled in minimum essential coverage and seeks to enroll in coverage separate from the perpetrator of the abuse or abandonment; or

(ii) Is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

(11) A qualified individual or dependent—

(i) Applies for coverage through NYSOH during the annual open enrollment period or due to a qualifying event, is assessed as potentially eligible for Medicaid or Child Health Plus and is determined ineligible for Medicaid or Child Health Plus either after open enrollment has ended or more than 60 days after the qualifying event; or

(ii) Applies for coverage at their Local Department of Social Services or Human Resources Administration during the annual open enrollment period, and is determined ineligible for Medicaid or Child Health Plus after open enrollment has ended;

(12) The qualified individual or enrollee, or his or her dependent, adequately demonstrates to NYSOH that a material error related to plan benefits, service area, or premium influenced the qualified individual's or enrollee's decision to purchase a qualified health plan; or

(13) At the option of NYSOH, the qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment following termination of enrollment due to a failure to verify such status within 90 days. NYSOH has not elected to adopt this subsection at this time.

(45 CFR § 155.420(d)).

Generally, if a triggering life event occurs, the qualified individual or enrollee has 60 days from the date of a triggering event to select a qualified health plan (45 CFR § 155.420(c)(1)).

## Legal Analysis

The first issue is whether NYSOH properly determined that you and your son were eligible for up to $559.00 per month in APTC.

The application that was submitted on February 5, 2018 listed an annual household income of $51,781.62 and the eligibility determination relied upon that information.

You expect to file your 2018 income tax return as married filing jointly and will claim one dependent on that tax return. Therefore, you and your son are in a three-person household.

You and your son reside in Suffolk County, where the second lowest cost silver plan available for a primary subscriber and one dependent through NYSOH costs $912.81 per month.

An annual income of $51,782.00 is 253.58% of the 2017 FPL for a three-person household. At 253.58% of the FPL, the expected contribution to the cost of the health insurance premium is 8.20% of income, or $354.04 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for a primary subscriber and one dependent in your county ($912.81 per month) minus your expected contribution ($354.04 per month), which equals $558.77 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your son to be eligible for up to $559.00 per month in APTC.

The second issue is whether you and your son were properly determined ineligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of $51,782.00 is 253.58% of the applicable FPL, NYSOH correctly found you and your son to be ineligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined you and your son were ineligible for the Essential Plan.

The Essential Plan is generally 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 $20,420.00 for a three-person household. Since an annual household income of $51,782.00 is 253.58% of the 2017 FPL, NYSOH correctly found you and your son to be ineligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that you and your son were ineligible for Medicaid.

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.

Medicaid can be provided through NYSOH to children age 19 or 20 whose primary residence is with their parents who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 155% of the FPL for the applicable family size.

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On the date of your application, the relevant FPL was $20,780.00 for a three-person household. Since $51,782.00 is 249.19% of the 2018 FPL, NYSOH properly found you and your son 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 submitted income documentation that shows in February 2018 your household income was at least $3,712.51.

You submitted income documentation that shows in March 2018 your household income was at least $3,854.93.

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 $2,390.00 per month. To be eligible for Medicaid, your son would need to meet the non-financial criteria and have an income no greater than 155% of the FPL, which is $2,685.00. Since the documentation you provided shows that your household income was at least $3,712.51 in February 2018 and at least $3,854.93 in March 2018, you and your son do not qualify for Medicaid based on monthly income as of the date of your February 5, 2018 and March 22, 2018 applications.

Therefore, the February 6, 2018 eligibility determination notice is AFFIRMED insofar as it properly stated that, based on the information you provided, you and your son were eligible for up to $559.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid.

During the hearing, you testified that your household income has changed. You submitted a Social Security Award letter that shows that your spouse's annual expected income is $26,256.00 ($2,188.00 for twelve months). You submitted paystubs that show that your son's annual expected income is $10,504.56 (three week gross income of $875.38 yields a weekly average of $291.79 multiplied by 36 weeks). You submitted paystubs that show that your annual expected income is $16,955.00, consisting of $12,021.50 from [redacted] (four week gross of $1,202.16 yields a weekly average of $300.54 multiplied by 40 weeks) and $4,933.50 from your second job (four week gross of $379.50 yields a weekly average of $94.88 multiplied by 52 weeks). Therefore, the documentation you submitted indicates that your household's annual expected income is $53,715.56.

Therefore, your case is RETURNED to NYSOH to redetermine your and your son's eligibility for financial assistance based on a household of three residing in Suffolk County with an annual expected income of $53,715.56.

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The fifth issue under review is whether NYSOH properly determined that you and your son do not qualify to enroll in a qualified health plan outside of the open enrollment period.

You testified that you are appealing the denial of a special enrollment period to enroll into a health plan through NYSOH. However, the record does not contain a notice of eligibility determination or redetermination denying you and your son a special enrollment period.

Here, the lack of a notice of eligibility determination denying you and your son a special enrollment periods 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 failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. Your credible testimony along with the February 6, 2018 appeal confirmation notice stating that the reason for your appeal was “denial of SEP”, as well as the recordings of the February 5, 2018 and March 22, 2018 phone calls, permits an inference that NYSOH did deny your special enrollment request.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it been issued.

NYSOH provided an open enrollment period from November 1, 2017 until January 31, 2018. On February 5, 2018, February 27, 2018, and March 22, 2018 you submitted applications for health insurance. On both February 5, 2018 and March 22, 2018 you requested to enroll yourself and your son in a qualified health plan.

Once the annual open enrollment period ends, a health plan enrollee must qualify for a special enrollment period in order to enroll in, or change to another health plan offered in NYSOH. In order to qualify for a special enrollment period, a person must experience a triggering event.

You testified, and the NYSOH system reflects, that you and your son previously had coverage under the Essential Plan in a different NYSOH account which ended on January 31, 2018. Loss of minimum essential coverage is considered a triggering life event.

When a triggering life event occurs, the qualified individual has 60 days from the date of that event to select a qualified health plan.

Since 60 days from January 31, 2018 is April 1, 2018; you and your son would have qualified to select a qualified health plan outside of the open enrollment period until April 1, 2018.

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The credible evidence of record indicates that your applications for health insurance were submitted on February 5, 2018, February 27, 2018, and March 22, 2018, prior to the expiration of the special enrollment period you should have been granted.

Therefore, NYSOH's verbal determination that you and your son do not qualify to select a health plan outside of the open enrollment period for 2018 is incorrect, you and your son should have been eligible for a special enrollment period as of the date of your February 5, 2018 and March 22, 2018 applications.

Additionally, a special enrollment period can be granted to an enrollee if a qualified individual's enrollment or non-enrollment into a qualified health plan is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of NYSOH or a non-NYSOH entity providing enrollment assistance or conducting enrollment activities.

On February 28, 2018, NYSOH issued a notice stating that you and your son qualified for a special enrollment and that you and your son needed to select and confirm a qualified health plan by April 1, 2018. You subsequently attempted to select a plan for yourself and your son on March 22, 2018, but were denied.

Since the February 28, 2018, determination notice stated you had until April 1, 2018 to select and confirm a qualified health plan, NYSOH had to honor this granting of a special enrollment period until April 1, 2018. It was in error that you were not allowed to select a plan on March 22, 2018.

Therefore, NYSOH's verbal determinations that you and your son do not qualify to select a health plan outside of the open enrollment period for 2018 is incorrect, you and your son should have been eligible for a special enrollment period as of the date of your February 5, 2018 application.

Your case is RETURNED to NYSOH to assist you and your son in enrolling into a qualified health plan. You may choose to enroll into a qualified health plan as of March 1, 2018 because you and your son would have been eligible for a special enrollment period due to your loss of minimum essential coverage, or as of May 1, 2018 because NYSOH failed to honor the special enrollment period it had granted to you and your son. In the alternative, you and your son may elect to enroll into coverage within 60 days from the date of this decision.

## Decision

The February 6, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your son's eligibility for financial assistance based on a household of three residing in Suffolk County with an annual expected income of $53,715.56.

NYSOH's verbal determination that you and your son do not qualify to select a health plan outside of the open enrollment period for 2018 is incorrect, you and your son should have been eligible for a special enrollment period as of your February 5, 2018 and March 22, 2018 applications.

Your case is RETURNED to NYSOH to assist you and your son in enrolling into a qualified health plan. You may choose to enroll into a qualified health plan as of March 1, 2018 or May 1, 2018, if you so choose. In the alternative, you and your son may elect to enroll into coverage within 60 days from the date of this decision. You will be responsible for premium payments for any months you and your son are enrolled into coverage.

## **Effective Date of this Decision:** May 24, 2018

## How this Decision Affects Your Eligibility

NYSOH properly found you and your son eligible for up to $559.00 per month in APTC effective March 1, 2018 based on the information in you February 5, 2018 application.

Your case is being sent back to NYSOH to redetermine your and your son's eligibility for financial assistance based on your testimony and the additional income documentation you submitted.

NYSOH improperly denied you and your son a special enrollment period.

Your case is being sent back to NYSOH to allow you and your son to enroll into coverage as of March 1, 2018 or May 1, 2018, if you so choose. In the alternative, you and your son may elect to enroll into coverage within 60 days from the date of this decision.

You will be responsible for any premium payments for any months you and your son are enrolled into coverage.

## If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If

your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 February 6, 2018 eligibility determination notice is AFFIRMED.

NYSOH properly found you and your son eligible for up to $559.00 per month in APTC effective March 1, 2018 based on the information in you February 5, 2018 application.

Your case is being sent back to NYSOH to redetermine your and your son's eligibility for financial assistance based on your testimony and the additional income documentation you submitted.

Your case is RETURNED to NYSOH to redetermine your and your son's eligibility for financial assistance based on a household of three residing in Suffolk County with an annual expected income of $53,715.56.

NYSOH improperly denied you and your son a special enrollment period.

NYSOH's verbal determination that you and your son do not qualify to select a health plan outside of the open enrollment period for 2018 is incorrect, you and your son should have been eligible for a special enrollment period as of your February 5, 2018 and March 22, 2018 applications.

Your case is being sent back to NYSOH to allow you and your son to enroll into coverage as of March 1, 2018 or May 1, 2018, if you so choose. In the alternative, you and your son may elect to enroll into coverage within 60 days from the date of this decision.

Your case is RETURNED to NYSOH to assist you and your son in enrolling into a qualified health plan. You may choose to enroll into a qualified health plan as of March 1, 2018 or May 1, 2018, if you so choose. In the alternative, you and your son may elect to enroll into coverage within 60 days from the date of this decision. You will be responsible for premium payments for any months you and your son are enrolled into coverage.

## Legal Authority

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).

We are sending you this notice in accordance with 45 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).

## 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 नि:शुल्क दोभाषे उपलब्ध गराउन सक्छौं।

**Polski (Polish)**

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

**Twi (Twi)**

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

**اردو (Urdu)**

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

**Tiếng Việt (Vietnamese)**

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

**אידיש (Yiddish)**

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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