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

Notice of Decision

Decision Date: May 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029778

[redacted]

Dear [redacted]

On May 3, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 23, 2018 eligibility determination notice and March 9, 2018 plan enrollment notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of NY State of Health.

If you have questions about your Decision, you can contact us by:

- Calling the Customer Service Center at 1-855-355-5777
- Sending Mail to:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the NY State of Health Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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

Decision

Decision Date: May 25, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029778

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were eligible for the Essential Plan with a $0.00 per month premium, effective April 1, 2018?
>
> Did NYSOH properly determined that your enrollment in the Essential Plan with a $0.00 per month premium was effective April 1, 2018?

Procedural History

On January 23, 2018, you applied for health insurance and financial assistance through NYSOH.

On January 24, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2018.

Also on January 24, 2018, NYSOH issued a notice stating that you were eligible for Medicaid retroactively from October 1, 2017 through December 31, 2017, because your household monthly income of $1,233.34 was at or below the allowable monthly income limit for Medicaid.

Also on January 24, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan, effective March 1, 2018.

Also on January 24, 2018, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end on March 1, 2018.

On February 22, 2018, you submitted an updated application for health insurance and financial assistance.

On February 23, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a $0.00 per month premium, effective April 1, 2018.

On March 5, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not eligible for the Essential Plan with a monthly premium, effective March 1, 2018.

On March 9, 2018, NYSOH issued a plan enrollment notice stating that you were enrolled in Essential Plan 2 Plus Vision and Dental with a monthly premium of $32.35 per month for vision and dental coverage, effective April 1, 2018.

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 closed at the end of the hearing.

Findings of Fact

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

1) You testified that you expect to file your tax return for 2018 with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking health insurance for yourself; specifically, the Essential Plan with a monthly premium, as of March 1, 2018.

3) There were two applications submitted on January 23, 2018. You testified and your NYSOH account confirms that you applied for health insurance that day with the assistance of an application counselor, and that you believed only one application was submitted. You also testified that you do not recall what amount of income you reported to your application counselor.

4) The first application that was submitted on January 23, 2018, listed annual household income of $17,400.00, consisting of income you earn from two employments. According to the Income Details in your NYSOH account, you attested that you work for one employer ([redacted] at $20.00 per hour for 10 hours per week, which equals

$10,400.00 annually (20 X 10 X 52), and receive annual income of $7,000.00 from a second employer [redacted]

5) The second application that was submitted on January 23, 2018, listed an annual household income of $14,800.00, consisting of income you earn from two employments. According to the Income Details in your NYSOH account, you attested that you work for one employer at $15.00 per hour for 10 hours per week, which equals $7,800.00 annually (15 x 10 x 52), and receive annual income of $7,000.00 from your second employer.

6) No explanation was provided in the second application submitted on January 23, 2018, as to the change of income being significantly decreased from the first application.

7) Your NYSOH account indicates that the preliminary determination for the first application submitted on January 23, 2018 stated that you were eligible for the Essential Plan. The preliminary determination for the second application stated that you were eligible for Medicaid based on monthly income of $1,233.00, and eligible for retroactive Medicaid for the months of October 2017, November 2017, and December 2017.

8) According to your NYSOH account, based on the second application submitted on your behalf on January 23, 2018, you had Medicaid Fee-For-Service from January 1, 2018 through March 31, 2018, as well as retroactive Medicaid for the months of October 2017, November 2017, and December 2017.

9) An updated application was systematically processed on February 22, 2018, based on annual household income of $17,400.00, consisting of income you earn from your employments, as noted in Fact # 5 above.

10) Your application states that you will not be taking any deductions on your 2018 tax return.

11) Your application states that you live in [redacted], NY.

12) You testified that you had fee-for-service Medicaid in March 2018, and that you used it to cover treatment that month in an [redacted].

13) You testified that you do not know if you have outstanding bills for medical services rendered in March 2018, because you have not received any bills.

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

Applicable Law and Regulations

Medicaid

Generally, most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage, even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as "continuous coverage" and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

In the following situations, individuals are not entitled to receive continuous coverage:

- Unable to locate;
- Death;
- Consumer requests to have his/her Medicaid closed;
- Failure to provide or cooperate in obtaining a Social Security Number, if otherwise required;
- Failure to provide documentation of citizenship after the reasonable opportunity period;
- Moved out of State;
- Coverage established under modified adjusted gross income (MAGI) in error;
- Undocumented pregnant women (only get 60 days post-partum);
- Failure to comply with absent parent (IV-D) requirements; and
- Individuals receiving treatment in a setting where Medicaid eligibility is not available

(*see* 42 CFR § 435.916(a); N.Y. Soc. Serv. Law § 366(4)(c); GIS 15 MA/22).

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 $12,060.00 for a one-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)).

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/downloads/ny-blueprint.pdf).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan with a $0.00 per month premium, effective April 1, 2018.

You testified that you are seeking Essential Plan with a monthly premium effective March 1, 2018.

Your NYSOH account indicates that you were determined eligible for fee-for-service Medicaid effective January 1, 2018, which continued through March 31, 2018, as well as retroactive fee-for-service Medicaid from October 1, 2017 through December 31, 2017. You testified and your NYSOH account confirms that you applied for health insurance on January 23, 2018 with the assistance of an application counselor. You further testified that you believed only one application was submitted and you do not recall what amount of income you reported to your application counselor. No explanation was provided in the second application submitted on January 23, 2018, as to the change of income being significantly decreased to $14,800.00 from the first application, in which it was reported as $17,400.00.

Based on the information contained in your NYSOH account as entered in the second of two separate applications on January 23, 2018, the income information provided in that application to determine your eligibility for Medicaid is suspect and appears to have been manipulated. However, NYSOH relied on that information in determining you eligible for Medicaid and you had the benefit of fee-for-service Medicaid from January 1, 2018 through March 31, 2018, and the benefit of retroactive fee-for-service Medicaid from October 1, 2017 through December 31, 2017.

Generally, under New York State law, once a person is eligible for Medicaid, that eligibility continues for 12 months, even if the household income rises above 138% of the FPL. This provision is called “continuous coverage.”

In your case, however, based on the income discrepancies in your January 23, 2018 applications, on February 22, 2018, NYSOH determined that your Medicaid coverage was established under MAGI in error, which is one of the situations in which an individual is not entitled to continuous coverage. Therefore, it is concluded that NYSOH properly determined that you were not entitled to receive continuous coverage in Medicaid when your eligibility for financial assistance was redetermined on February 22, 2018.

The record reflects that, when your eligibility for financial assistance was systematically redetermined that day, it was based on an annual household income of $17,400.00.

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2018 income tax return as single and will claim no dependents on that tax return.

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. A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution, and 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

On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since an annual household income of $17,400.00 is 144.28% of the 2017 FPL, NYSOH correctly found you to be eligible for the Essential Plan. Since your household income was 144.28% of the 2017 FPL, which is below 150% of the FPL, NYSOH also properly determined you had a $0.00 monthly premium contribution.

Since the February 23, 2018 eligibility determination notice properly stated that, based on the information in your NYSOH account, you were eligible for the Essential Plan with a $0.00 per month premium, it is correct and is AFFIRMED.

The second issue under review is whether NYSOH properly determined that your enrollment in the Essential Plan was effective April 1, 2018.

According to your NYSOH account, you enrolled into an Essential Plan on March 8, 2018, including Vison and Dental coverage costing $32.35 per month.

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.

On March 8, 2018, you selected an Essential Plan, so your enrollment properly took effect on the first day of the first month following March 2018; that is, on April 1, 2018.

Therefore, the March 9, 2018 plan enrollment notice stating that your enrollment in the Essential Plan was effective April 1, 2018, is correct and must be AFFIRMED.

Decision

The February 23, 2018 eligibility determination notice is AFFIRMED.

The March 9, 2018 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: May 25, 2018

How this Decision Affects Your Eligibility

You were properly determined eligible for the Essential Plan with a $0.00 per month premium, effective April 1, 2018.

You were properly enrolled in an Essential Plan 2 Plus Vison and Dental coverage costing $32.35 per month, effective April 1, 2018.

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 23, 2018 eligibility determination notice is AFFIRMED.

The March 9, 2018 plan enrollment notice is AFFIRMED.

You were properly determined eligible for the Essential Plan with a $0.00 per month premium, effective April 1, 2018.

You were properly enrolled in an Essential Plan 2 Plus Vison and Dental coverage costing $32.35 per month, effective April 1, 2018.

Legal Authority

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:

[redacted]

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई 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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