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

Notice of Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014098

[redacted]

Dear [redacted],

On March 9, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 2, 2016 notice that in part contained an eligibility redetermination for coverage in the upcoming coverage year.

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 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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NY State of Health Account ID: [redacted]
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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 spouse were eligible to enroll in the Essential Plan effective February 1, 2017?
>
> Did NY State of Health properly determine that you and your spouse were not eligible for Medicaid, as of January 31, 2017?

Procedural History

On November 21, 2016, NY State of Health (NYSOH) received your updated application for financial assistance.

On November 22, 2016, NYSOH issued an eligibility determination notice stating that you and your spouse were no longer eligible for Medicaid. However, your Medicaid coverage would continue until January 31, 2017 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of November 1, 2016.

On December 2, 2016, NYSOH issued a notice stating that it was time to renew your and your spouse's health insurance for the next coverage period. The notice also stated that, based on information from federal and state sources, NYSOH had determined that you and your spouse were eligible for the Essential Plan with a $20.00 monthly premium each, effective February 1, 2017. The notice

further stated that you had been enrolled in an Essential Plan that was similar to the coverage you had before with the same insurance company.

On December 16, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the December 2, 2016, eligibility determination insofar as you and your spouse were not eligible for Medicaid as of January 31, 2017.

On December 17, 2016, NYSOH issued an enrollment notice confirming your and your spouse's enrollment in Essential Plan 1 with a $20.00 monthly premium each, effective February 1, 2017.

Also on December 17, 2016, NYSOH issued a disenrollment notice stating that your and your spouse's coverage in your Medicaid Managed Care (MMC) plan would end on January 31, 2017. This was because you were no longer eligible to remain enrolled in your current health insurance.

On December 20, 2016, you requested Aid to Continue so that your and your spouse's coverage under your MMC plan could continue pending the outcome of this appeal.

On December 21, 2016, NYSOH granted your request for Aid to Continue.

On December 22, 2016, NYSOH issued an eligibility redetermination notice stating that you and your spouse were eligible for Medicaid for a limited time because you had been granted Aid to Continue until a decision is made on your appeal.

On December 24, 2016, NYSOH issued an enrollment notice confirming you and your spouse had coverage through your MMC plan as of February 1, 2017

On March 9, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You testified that you expect to file your 2016 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.

2) You are seeking insurance for you and your spouse.

3) The application that was submitted on November 21, 2016, in which you requested financial assistance, listed annual household income of

$31,200.00. You testified that your spouse earns $600.00 per week from his steady employment and you do not work because of your health. You testified you did not expect these circumstances to change. You testified that the $31,200 household income is correct.

4) According to your NYSOH account and your testimony, you will not be taking any deductions on your 2016 tax return.

5) You testified that you have serious health issues and that, after paying for basic household living expenses, you cannot afford to pay for health insurance.

6) According to your NYSOH account and your testimony, you and your spouse live in [redacted], New York.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

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 2015 FPL, which is $15,930.00 for a two-person household (80 Fed. Reg. 3236, 3237).

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 2016 FPL, which is $16,020.00 for a two-person household (81 Fed. Reg. 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Legal Analysis

The issues under review are whether NYSOH properly determined that you and your spouse were eligible for the Essential Plan, effective February 1, 2017 and no longer eligible for Medicaid through NYSOH as of January 31, 2017.

Initially, NYSOH is required to redetermine Medicaid eligibility once every twelve months. It is noted that your and your spouse's 12 months of continues coverage was due to end on January 31, 2017. Therefore, NYSOH issued notices regarding its redetermination of your and your spouse's eligibility for financial assistance as of the upcoming renewal date of February 1, 2017.

The application that you submitted on November 21, 2016 and the system updated application of December 1, 2016 listed an annual household income of $31,200.00. The eligibility determinations relied upon that information, which you testified was correct.

You are in a two-person household for purposes of this analysis. This is because you expect to file your 2016 income taxes as married filing jointly and will claim no dependents on that tax return.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% of the FPL for the applicable family size. On the date of your applications, the relevant FPL was $15,930.00 for a two-person household. Since an annual household income of $31,200.00 is 195.85% of the 2015 FPL, NYSOH properly found you to be eligible for the Essential Plan, effective February 1, 2017.

However, you expressly requested in your appeal to be reconsidered 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. On the dates of your applications, the relevant FPL was $16,020.00 for a two-person household. Since $31,200.00 is 194.75% of the 2016 FPL, NYSOH properly found you and your spouse to be ineligible for Medicaid as of February 1,2017 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 testified that your household's only source of income is your spouse's weekly wages from his steady employment. You testified that your spouse earns $600.00 every week and you did not expect this to change.

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 $1,844.00 per month. There is nothing in the record to suggest you do not meet the non-financial criteria, so the analysis turns to the financial criteria. Since your monthly income of $2,400.00 is greater than the maximum monthly allowable income limit of $1,844.00 for a two-person household, you and your spouse do not qualify for Medicaid based on monthly income as of the date of your application.

Since the November 22, 2016, eligibility redetermination properly stated that, based on the information you provided, you and your spouse were ineligible for Medicaid, but your Medicaid coverage would continue until January 31, 2017 because you and your spouse qualified for twelve continuous months of coverage, it was correct and is AFFIRMED.

Since the December 2, 2016, eligibility redetermination as contained in the renewal notice properly stated that, based on the information you provided, you and your spouse were eligible for the Essential Plan effective February 1, 2017, it was correct and is AFFIRMED.

Decision

The November 22, 2016 eligibility redetermination notice is AFFIRMED.

The December 2, 2016 eligibility redetermination notice is AFFIRMED.

Effective Date of this Decision: April 21, 2017

How this Decision Affects Your Eligibility

You and your spouse remain eligible for the Essential Plan.

You and your spouse are not eligible for Medicaid after January 31, 2017, because your monthly and annual income was above the maximum allowable income limit for a two-person household.

Your case is being returned to NYSOH to assist you and your spouse in selecting and enrolling in an Essential Plan as soon as is feasible.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 after 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 U.S. Department of Health and Human Services. 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 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 November 22, 2016 eligibility redetermination notice is AFFIRMED.

The December 2, 2016 eligibility redetermination notice is AFFIRMED.

You and your spouse remain 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 and your spouse are not eligible for Medicaid after January 31, 2017, because your monthly and annual income was above the maximum allowable income limit for a two-person household.

Your case is being returned to NYSOH to assist you and your spouse in selecting and enrolling in an Essential Plan as soon as is feasible.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

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A Copy of this Decision Has Been Provided To:

[redacted]

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Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

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

Italiano (Italian)

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

한국어 (Korean)

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

Русский (Russian)

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

العربية (Arabic)

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

বাংলা (Bengali)

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

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Français (French)

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

हिंदी (Hindi)

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

日本語 (Japanese)

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

नेपाली (Nepali)

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

Polski (Polish)

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

Twi (Twi)

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

اردو (Urdu)

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

Tiếng Việt (Vietnamese)

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

אידיש (Yiddish)

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

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