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

Notice of Decision

Decision Date: March 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014389

[redacted]

Dear [redacted]

On March 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 23, 2016 eligibility determination.

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).

This page intentionally left blank.

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).

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

Decision

Decision Date: March 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014389

[redacted]

Issues

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

> Was your appeal of NY State of Health's (NYSOH) July 17, 2016 eligibility determination and disenrollment notices, and the August 4, 2016 eligibility determination notice, timely?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid in the month of August 2016?

Procedural History

On June 15, 2016, NYSOH issued a notice that it was time to renew your health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not determine whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by July 15, 2016, or you might lose the financial assistance you were currently receiving.

No updates were received by July 15, 2016, and NYSOH redetermined your eligibility for financial assistance with health insurance.

On July 17, 2016, NYSOH issued a notice of eligibility determination stating that you were newly eligible to purchase a qualified health plan at full cost, effective August 1, 2016.

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).

Also on July 17, 2016, NYSOH issued a notice of disenrollment stating that your coverage in your Essential Plan was terminated, effective July 31, 2016.

On August 3, 2016, you updated your NYSOH account.

On August 4, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan for a limited time, effective September 1, 2016, pending documentation of your income.

On August 4, 2016, documentation was faxed to NYSOH on your behalf and was uploaded to your NYSOH account on August 6, 2016.

On August 12, 2016, NYSOH issued notice of eligibility determination stating that you and your son were eligible to receive up to $362.00 per month in advance payments of the premium tax credit (APTC), and eligible for cost-sharing reductions, effective September 1, 2016.

On August 16, 2016, you updated your NYSOH account.

On August 17, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $188.00 in APTC, and eligible for cost-sharing reductions, effective October 1, 2016.

Also on August 17, 2016, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a qualified health plan, beginning on October 1, 2016.

On November 22, 2016, you updated your NYSOH application and requested assistance with medical bills from the month of August 2016.

On November 23, 2016, NYSOH issued a notice of eligibility determination stating that you were not eligible to receive help paying medical bills for the period of August 1, 2016 through August 31, 2016 because the program you were eligible for cannot pay for any care you received in the past.

On December 28, 2016, you spoke to NYSOH's Account Review Unit and appealed the July 17, 2016 eligibility determination and disenrollment notices, insofar as they ended your Essential Plan coverage, and the November 23, 2016 eligibility determination notice, insofar as it denied retroactive Medicaid for the month of August 2016.

On March 7, 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 support the following findings of fact:

1) Your NYSOH account reflects that you receive notices from NYSOH by regular mail

2) You testified that your mailing address was the same in June 2016 as it is now.

3) You testified that you did not receive the June 15, 2016 renewal notice, and that you did not know that your Essential Plan coverage had ended until you tried to make an appointment with a doctor in early August and were told that you did not have coverage.

4) Not notices sent to you at the address in your NYSOH account have been returned to NYSOH as undeliverable.

5) You testified that you contacted NYSOH and were informed that your coverage had ended on July 31, 2016.

6) Your NYSOH account reflects that you updated your NYSOH application on August 3, 2016.

7) Your November 22, 2016 application, which requested assistance with medical bills from the month of August 2016, stated that you expect to file your taxes with a tax filing status of single, and did not list any dependents.

8) You testified that you will be claiming your son and your daughter as dependents on your 2016 tax return.

9) Your NYSOH account reflects that you removed your daughter from your account in your August 16, 2016 application.

10) You testified that your daughter is a full-time college student, and that when she is home, she lives with you, but spends most of her time with her boyfriend.

11) You testified that your daughter works part-time, but does not make much.

12) You testified that your son graduated from high school in June 2016, and that he is currently working. You testified that he will be filing a tax return, but you will claim him as a dependent.

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).

13) You testified that your son was working at [redacted] in August 2016, and had not yet started the job he is currently working, which he began in October 2016.

14) On February 9, 2017, you uploaded documentation to your NYSOH account, including four paystubs from [redacted] for August 2016 for the following dates and gross earnings:

a. August 5, 2016 - $640.00 (Document [redacted]);
b. August 12, 2016 - $640.00 (Document [redacted]);
c. August 19, 2016 - $640.00 (Document [redacted]);
d. August 26, 2016 - $700.00 (Document [redacted]).

15) On September 14, 2016, documentation was faxed to NYSOH on your behalf, including two biweekly paystubs for your son from [redacted] for the following dates and gross earnings:

a. August 11, 2016 - $800.38;
b. August 25, 2016 - $617.79;

(Document [redacted]).

16) Documentation uploaded to your NYSOH account on February 11, 2017 shows that your son grossed $10,781.86 in earnings from [redacted] in 2016 (Document [redacted]).

17) Additionally, documentation uploaded to your NYSOH account on January 3, 2017 shows that your son also grossed at least $2,861.48 in earnings in 2016 from a job he started on October 17, 2016 (Document [redacted]).

18) You testified that you are looking for coverage for the month of August 2016 because you have medical bills from that month, and because you never received the June 2016 notice stating that you needed to renew your eligibility.

19) You testified that you are not sure why you did not file an appeal any sooner, but that you filed it as soon as you received the documentation regarding the denial of coverage for August 2016.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR 155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

Medicaid for Adults between the Ages of 19 and 65

Medicaid through NYSOH can be provided 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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 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 $20,160.00 for a three-person household (81 Federal Register 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).

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied (42 CFR § 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Dependent Income

NYSOH bases its eligibility determinations on modified adjusted gross income (MAGI) as defined in the federal tax code (45 CFR § 155.300(a), 42 CFR § 603(e), *see* 26 USC §36B(d)(2)(B)).

Regarding eligibility for financial assistance through NYSOH, 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)).

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 2016 year, a dependent who had yearly gross earned income greater than $6,300.00 or gross unearned income greater than $1,000.00 would be required to file a tax return (see IRS Publication 929).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's July 17, 2016 eligibility determination and disenrollment notices was timely.

On June 15, 2016, NYSOH issued a notice stating that it was time to renew your application for health insurance. Since you did not respond to this renewal notice within the required timeframe, NYSOH found you ineligible for financial assistance effective August 1, 2016, and disenrolled you from your Essential Plan coverage, effective July 31, 2016.

The record reflects that you updated your account on August 3, 2016 and were found eligible to re-enroll in the Essential Plan as of September 1, 2016. Subsequently, you updated your account, which resulted in eligibility determinations stating that you were eligible to receive APTC as of September 1, 2016.

Although you repeatedly updated your application, the record reflects that the first time you called NYSOH to file a complaint about not having coverage for the month of August was on December 28, 2016, when you filed your formal appeal.

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been timely on the issue of your disenrollment from your Essential Plan coverage, as stated in the July 17, 2016 notice, an appeal should have been filed by September 15, 2016, and for an appeal of the August 4, 2016

eligibility determination notice (which stated that your eligibility began again on September 1, 2016) to have been timely, it would have to have been filed by October 3, 2016. According to credible evidence in the record, you did not contact NYSOH until December 28, 2016 to file a formal appeal, which is well beyond 60 days from the July 17, 2016 disenrollment and August 4, 2016 eligibility determination notices.

You testified that you did not receive the renewal notice, and did not know that your coverage was coming to an end. However, none of the notices at issue here was returned to NYSOH as undeliverable. Moreover, you testified that you knew as of early August 2016 that there was a problem with your coverage, at which point a timely appeal could have been filed, but you did not file an appeal at that time.

Therefore, there has been no timely appeal of the July 17, 2016 eligibility determination or disenrollment notices, nor the August 4, 2016 eligibility determination notice, and your appeal on the issue of the cancellation of your Essential Plan for the month of August 2016, as stated in those notices, is DISMISSED.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid in the month of August 2016.

When an individual files an initial application for Medicaid, his or her eligibility for retroactive Medicaid depends on the date of application. To this end, it does not matter whether that initial application resulted in Medicaid eligibility going forward. Instead, an individual, who has filed an initial application for Medicaid through NYSOH, has the right to be evaluated for Medicaid for the three months before the month of his or her application.

Medicaid coverage can be made effective retroactively for up to three months prior to an individual's initial application if the individual received medical services that would have been covered under Medicaid and if they would have been eligible for Medicaid in those three months had they applied.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. To be eligible for Medicaid in August 2016, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria during August 2016.

The November 22, 2016 application stated that you expected to file your tax return with a tax filing status of single, and to claim no dependents on that tax return. You uploaded documentation that showed that your gross income in the month of August was $2,620.00.

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).

However, at the hearing, you testified that there are three people in your household, as your daughter still lives with you when she is not at school, and you claim both her and your son as dependents. Therefore, your household size for purposes of determining Medicaid eligibility would be three, and not one. Additionally, according to documentation in the record, your son's gross income for 2016 is more than the $6,300.00 maximum that a dependent can earn without having to file a tax return. Therefore, since your son must file a tax return, his income would also count in any determination regarding your eligibility for Medicaid in August 2016.

As the record stands now, your NYSOH account does not contain accurate information regarding your tax filing status, nor does it contain any information about your daughter, whom you expect to claim as a dependent, and whom you testified still resides in your household.

Ordinarily, your case would be returned to NYSOH to give you time to update your application. However, the documentation you submitted shows that your gross household income for the month of August 2016 is already $4,038.17 when your son's income is added in. To be eligible for Medicaid in the month of August 2016 (presuming your household size is three), your income would have to have been less than 138% of the FPL for a three-person household, which is $2,318.40. Since an income of $4,038.17 is greater than $2,318.40, you were not financially eligible for Medicaid in the month of August 2016.

Therefore, the November 23, 2016 eligibility determination stating that you were not eligible for Medicaid in the month of August 2016 is AFFIRMED.

You are responsible for reporting any changes that might affect your household's eligibility for financial assistance to NYSOH within 30 days of the change. This includes changes in household size, and tax filing status.

Decision

Your appeal of the July 17, 2016 disenrollment and eligibility determination notices, and the August 4, 2016 eligibility determination notice, is untimely and is DISMISSED.

The November 23, 2016 eligibility determination stating that you were not eligible for Medicaid in the month of August 2016 is AFFIRMED.

Effective Date of this Decision: March 28, 2017

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).

How this Decision Affects Your Eligibility

Your appeal of the July 31, 2016 termination of your Essential Plan coverage was not timely and is dismissed.

You are not eligible for Medicaid in the month of August 2016.

You must update your NYSOH account to reflect the accurate tax filing status of everyone in your household to ensure that you are receiving the proper amount of financial assistance.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:

  Health Insurance Marketplace
  Attn: Appeals
  465 Industrial Blvd.
  London, KY 40750-0061

- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

If you 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).

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

Your appeal of the July 17, 2016 disenrollment and eligibility determination notices, and the August 4, 2016 eligibility determination notice, is untimely and is DISMISSED.

The November 23, 2016 eligibility determination stating that you were not eligible for Medicaid in the month of August 2016 is AFFIRMED.

Your appeal of the July 31, 2016 termination of your Essential Plan coverage was not timely and is dismissed.

You are not eligible for Medicaid in the month of August 2016.

You must update your NYSOH account to reflect the accurate tax filing status of everyone in your household to ensure that you are receiving the proper amount of financial assistance.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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

Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

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

Italiano (Italian)

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

한국어 (Korean)

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

Русский (Russian)

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

العربية (Arabic)

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

বাংলা (Bengali)

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

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

Français (French)

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

हिंदी (Hindi)

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

日本語 (Japanese)

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

नेपाली (Nepali)

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

Polski (Polish)

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

Twi (Twi)

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

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.

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).