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

Notice of Decision

Decision Date: May 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014838

Dear

On April 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 12, 2017 eligibility determination notice.

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

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

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

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211
- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and 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 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014838

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 to enroll in the Essential Plan for a limited time, effective February 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid as of February 1, 2017?

Procedural History

On October 14, 2016, you submitted an application for financial assistance.

On October 15, 2016, NYSOH issued an eligibility determination stating that you were conditionally eligible for Medicaid, effective October 1, 2016. The notice directed you to provide proof of your Social Security number by January 12, 2017.

Also on October 15, 2016, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a Medicaid Managed Care plan, effective November 1, 2016. The notice directed you to provide proof of your Social Security number by January 12, 2017.

On November 18, 2016, you uploaded a copy of your Social Security card to your NYSOH account.

On December 7, 2016, NYSOH issued a notice of eligibility redetermination stating that you remained conditionally eligible for Medicaid, effective December

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1, 2016. The notice directed you to provide proof of your Social Security number by January 12, 2017.

On December 26, 2016, you uploaded a copy of your Social Security card to NYSOH.

On January 11, 2017, NYSOH received your updated application for financial assistance.

On January 12, 2017, NYSOH issued an eligibility determination, based on the January 11, 2017 application, stating that you were eligible to enroll in the Essential Plan for a limited time, effective February 1, 2017. It further stated that you no longer qualified for Medicaid as of January 31, 2017. The notice directed you to provide income documentation by April 11, 2017.

On January 13, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of your eligibility for the Essential Plan, insofar as you were not eligible for Medicaid. You also requested Aid to Continue, pending the outcome of your appeal.

On January 19, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid for a limited time, effective February 1, 2017, because you had been granted Aid to Continue, pending the outcome of your appeal. You were also re-enrolled into a Medicaid Managed Care plan as of February 1, 2017, pursuant to your request for Aid to Continue.

On April 26, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [redacted] acted as your authorized representative and assisted you with your testimony. Also during the hearing Russian Interpreter [redacted] provided interpretation services. 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) Your Authorized Representative testified that you attempted to upload your Social Security card to your NYSOH account on November 18, 2016 but were unsuccessful.

2) Your NYSOH account reflects that a copy of your Social Security card does appear to have been uploaded to your account on November 18, 2016.

3) Your NYSOH account reflects that, on December 6, 2016, NYSOH verified the Social Security card that your spouse uploaded, but did not verify the Social Security card that you uploaded.

4) Your Authorized Representative testified and your NYSOH account reflects that you uploaded your Social Security card to your NYSOH account on December 26, 2016.

5) The application that was submitted on January 11, 2017, which requested financial assistance, listed annual household income of $29,151.20, consisting of $29,151.20 your spouse earns from his employment.

6) On January 12, 2017, you were determined eligible for the Essential Plan for a limited time, effective February 1, 2017.

7) On January 12, 2017, you were determined no longer eligible for Medicaid effective January 31, 2017.

8) NYSOH records reflect that there is no official determination finding you eligible for Medicaid without limitations/conditions.

9) Your authorized representative testified that you are appealing your Essential Plan eligibility, insofar as you are seeking Medicaid coverage.

10) Your application states that you will not be taking any deductions on your 2016 tax return.

11) Your application states that you live in Kings County.

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

Applicable Law and Regulations

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR

§ 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is $16,020.00 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 Continuous Coverage

Generally, individuals 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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective February 1, 2017.

The application that was submitted on January 11, 2017 listed an annual household income of $29,151.20 and the eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2017 income taxes as married filing jointly.

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 application, the relevant FPL was $16,020.00 for a two-person household. Since an annual household income of $29,151.20 is 181.96% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

The second issue is whether NYSOH properly determined that you were not eligible for Medicaid, effective February 1, 2017.

The October 15, 2016 eligibility determination stated that you were conditionally eligible for Medicaid, effective October 1, 2016 and directed you to provide proof of your Social Security number by January 12, 2017.

The December 7, 2016 eligibility redetermination stated that you remained conditionally eligible for Medicaid, effective December 1, 2016. The notice directed you to provide proof of your Social Security number by January 12, 2017.

NYSOH records reflect that you uploaded a copy of your Social Security card to your NYSOH account on November 18, 2016 and December 26, 2016. On January 11, 2017, you updated your annual household income to $29,151.20, resulting in the January 12, 2017 eligibility determination finding that you were eligible to enroll in the Essential Plan for a limited time, effective February 1, 2017. NYSOH records reflect that there was no official determination finding you eligible for Medicaid without conditions.

Because the December 7, 2016 notice found you only conditionally eligible for Medicaid (effective December 1, 2016) and there was no official notice finding you fully eligible for Medicaid, the Medicaid continuous coverage policy did not apply to you. When you updated your income on January 11, 2017, your eligibility changed to the Essential Plan, effective February 1, 2017. Therefore, the January 12, 2017 eligibility determination correctly found that you no longer qualified for Medicaid as of January 31, 2017.

Since the January 12, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan, and not eligible for Medicaid, it was correct and is AFFIRMED.

Decision

The January 12, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 23, 2017

How this Decision Affects Your Eligibility

You remain eligible for the Essential Plan.

You are not eligible for Medicaid.

If You Disagree with this Decision (Appeal Rights)

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

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

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

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

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

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

- By fax: 1-877-369-0129

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

If You Have Questions about this Decision (Customer Service Resources):

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The January 12, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for the Essential Plan.

You are not eligible for Medicaid.

Legal Authority

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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.

(Urdu)اردو

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

Tiếng Việt (Vietnamese)

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

אידיש (Yiddish)

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

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