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

# Notice of Decision

Decision Date: May 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015141

[redacted]

Dear [redacted],

On April 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 14, 2016 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 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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DEPARTMENT OF HEALTH
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# Decision

Decision Date: May 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015141

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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 were eligible for the Essential Plan, effective January 1, 2017?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid?

## Procedural History

On November 26, 2016, you submitted an application for financial assistance and per NYSOH's request, submitted four consecutive paystubs dated November 2016, which were subsequently validated by NYSOH on December 13, 2016 (*see* Document [redacted].

On December 14, 2016, NYSOH issued an eligibility determination notice, based on the December 13, 2016 updated application, stating that you were eligible to enroll in the Essential Plan with a premium of $20 per month, effective January 1, 2017.

On January 25, 2017, you spoke to NYSOH's Account Review Unit and appealed only your ineligibility for Medicaid.

On January 26, 2017, NYSOH issued an eligibility redetermination notice stating that you were eligible to enroll in the Essential Plan for a limited time, effective March 1, 2017.

On April 19, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to May 5, 2017, to allow you to submit supporting documents.

On May 3, 2017, you submitted your 2016 executed income tax return, your 2016 W-2 wage statement, and eight paystubs dated December 9, 2016 through February 3, 2017. These documents were made part of the record collectively as "Appellant's Exhibit A." The record is now closed.

## Findings of Fact

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

1) You testified that you expect to file your 2017 taxes using a tax filing status of single. You will claim no dependents on that tax return.

2) You testified that you are seeking to have your eligibility redetermined for Medicaid.

3) The updated application that was submitted on December 13, 2016, and based upon your validated income documents, listed annual household income of $18,917.99, consisting of $18,917.99 you earn from your employment. You testified that this amount was correct.

4) You testified, and provided documentation showing, that your monthly income for December 2016 was $1,392.74. This monthly income was calculated as follows:

| | |
|---|---|
| December 30, 2016 Year-to-Date (YTD): | $18,087.55 |
| Less November 25, 2016 YTD: | -$16,694.81 |
| | $ 1,392.74 |

(*see* Appellant's Exhibit A, p.1; Document [redacted]).

5) You testified, and provided documentation showing, that you did not take any deductions on your 2016 tax return (see Appellant's Exhibit A, pp. 5-6).

6) According to your NYSOH account and your testimony, you live in Niagara County, NY.

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 November 12, 2016 and January 25, 2017 applications, that was the 2015 FPL, which is $11,770.00 for a one-person household (80 Federal Register 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)).

De Novo Review

The Marketplace 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).

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 November 12, 2016 and January 25, 2017 applications, that was the 2016 FPL, which is $11,880.00 for a one-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 first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective January 1, 2017.

You expect to file as single for the 2017 tax year and claim no dependents. Therefore, you are in a one-person household for purposes of these analyses.

You testified and submitted documentation reflecting that your annual household income is expected to be $18,917.99. NYSOH relied upon this information.

The Essential Plan is 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 $11,770.00 for a one-person household. Since an annual household income of $18,917.99 is 160.73% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan, based on the income documentation you provided.

Since the December 14, 2016 eligibility determination notice properly stated in part that you were eligible for the Essential Plan, effective January 1, 2017, based on the information in your NYSOH account at that time, it is correct and must be AFFIRMED as to your eligibility.

The same result is reached using the information on your January 25, 2017 updated application since your household income amount, household size, and relevant FPL remained the same.

Therefore, the remaining issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

On January 25, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal of your eligibility determination; specifically, that you wanted to be redetermined eligible for free health insurance. The record does not contain an eligibility determination or redetermination notice on the issue of your request for Medicaid. It does contain a January 26, 2017 notice that acknowledges you as the appellant and identifies the issue on appeal as "Eligibility Determination," and your testimony that you would like to be redetermined eligible for Medicaid.

Here, the lack of an eligibility determination or redetermination notice on the issue of Medicaid eligibility 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's failure to timely issue an eligibility determination or redetermination notice as you are to appeal an adverse notice of eligibility determination. The record, including the January 26, 2017 notice along with your testimony, demonstrates that you did request an appeal on your eligibility determination as it relates to your eligibility for Medicaid. Therefore, it is reasonable to find that this evidence constitutes an appeal on the issue of your eligibility for Medicaid and permits an inference that NYSOH did deny your request to be determined eligible for Medicaid.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to any notice of eligibility determination had it been issued. Therefore, the issue under review is refined to whether NYSOH properly found you ineligible for Medicaid as of December 1, 2016.

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 date of your applications, the relevant FPL was $11,880.00 for a one-person household. Since $18,917.99 is 159.24% of the 2016 FPL, you were ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

This is also so using your monthly income from December 2016. 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 paystubs that show in December 2016 you received $1,392.74 in earned income.

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 $1,367.00 per month. Since the documentation you provided shows that your gross earnings were $1,392.74 in December 2016, you do not qualify for Medicaid based on monthly income as of December 13, 2016.

Since the December 14, 2016 eligibility determination and January 26, 2017 redetermination notices properly stated that, based on the information you provided, you were eligible for the Essential Plan, those notices are correct and are AFFIRMED.

By this Decision, you were not eligible for Medicaid as of December 1, 2016.

## Decision

The December 14, 2016 eligibility determination and January 26, 2017 redetermination notices are AFFIRMED.

By this Decision, you were not eligible for Medicaid as of December 1, 2016.

## Effective Date of this Decision: May 11, 2017

## How this Decision Affects Your Eligibility

You were eligible for the Essential Plan, effective January 1, 2017, but for a limited time pending proof if income by April 25, 2017.

You were ineligible for Medicaid as of December 1, 2016.

## 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 December 14, 2016 eligibility determination and January 26, 2017 redetermination notices are AFFIRMED.

By this Decision, you were not eligible for Medicaid as of December 1, 2016.

You were eligible for the Essential Plan, effective January 1, 2017, but for a limited time pending proof if income by April 25, 2017.

You were ineligible for Medicaid as of December 1, 2016.

## Legal Authority

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

## 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 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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