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

Notice of Decision

Decision Date: May 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015176

[redacted]

Dear [redacted],

On April 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 11, 2017 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 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 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015176

[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 to enroll in the Essential Plan with a $20.00 monthly premium, effective February 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid, as of January 10, 2017?

Procedural History

On January 12, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective February 1, 2016. You were also enrolled into a Medicaid Managed Care plan, beginning February 1, 2016.

On December 4, 2016, NYSOH issued a renewal notice stating that it was time to renew your application for health insurance for 2017. The notice directed you to update your application between December 16, 2016 and January 15, 2017, or the financial assistance you were currently receiving may end.

On January 10, 2017, you updated your NYSOH account and submitted an application for financial assistance with health insurance.

On January 11, 2017, NYSOH issued an eligibility determination based on the January 10, 2017 application, stating that you were eligible to enroll in the

Essential Plan with a $20.00 monthly premium, effective February 1, 2017. It further stated that you no longer qualified for Medicaid as of January 31, 2017.

Also on January 11, 2017, NYSOH issued a notice of enrollment confirmation confirming your enrollment in an Essential Plan 1 through Healthfirst for a monthly premium of $47.49, including dental and vision coverage, with an enrollment start date of February 1, 2017.

On January 25, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination, insofar as you were not eligible for the Essential Plan with no monthly premium, or Medicaid.

On April 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, a Spanish-language interpreter, ID Number [redacted], provided assistance. The record was developed during the hearing and kept open for fifteen days at the end of the hearing to give you time to submit documentation of your income received in the month of February 2017.

On May 4, 2017, you faxed a five-page document to the Appeals Unit, and on May 10, 2017, you faxed a six-page document to the Appeals Unit. 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 with a tax filing status of single. You will claim no dependents on that tax return.

2) The application that was submitted on January 10, 2017, which requested financial assistance, listed annual household income of $18,360.00, consisting of income you earn from employment.

3) You testified that your W2 for 2016 showed annual income of $18,579.00, and that you expect your 2017 income to be approximately the same.

4) You testified that you were not sure what your income was for the month of February 2017, so the record was left open after the hearing to provide you with the opportunity to submit income documentation for the month of February.

5) On May 4, 2017, you faxed a five-page document consisting of the following:

    a. A one-page fax cover sheet;

b. A paystub dated 2/9/17 for $451.00 in gross income;
c. A paystub dated 2/16/17 for $270.00 in gross income;
d. A paystub dated 2/23/17 for $446.90 in gross income;
e. A paystub dated 3/9/17 for $475.60 in gross income;

These documents are collectively marked and entered into the record as "Appellant's Exhibit One."

6) On May 10, 2017, you faxed a six-page document consisting of a fax cover sheet, the same four paystubs listed above, and a paystub for 2/2/17 for $426.40 in gross income, and $1,668.70 in year-to-date income. These documents are collectively marked and entered into the record as "Appellant's Exhibit Two."

7) Your application states that you will not be taking any deductions on your 2017 tax return, and your confirmed this in your testimony.

8) You testified that you are looking to be eligible for the Essential Plan with no premium, or for Medicaid, because the coverage that you have now is too expensive, and that you need affordable coverage because you have health problems.

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 $11,880.00 for a one-person household (81 Fed. Reg. 4036.).

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 $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 with a $20.00 monthly premium, effective February 1, 2017.

The application that was submitted on January 10, 2017 listed an annual household income of $18,360.00, and the eligibility determination relied upon that information.

You are in a one-person household. You expect to file your 2017 income taxes as single, 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 application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $18,360.00 is 154.55% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

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. Since $18,360.00 is 154.55% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan with a $20.00 monthly premium, based on your expected annual income.

The second issue under review is whether NYSOH properly determined that you were not eligible 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 date of your application, the relevant FPL was $11,880.00 for a one-person household. Since $18,360.00 is 154.55% of the 2016 FPL, NYSOH properly found you to be ineligible for Medicaid 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. The record was left open after the hearing so that you could submit copies of all paystubs received in the month of February 2017.

You submitted a paystub dated February 2, 2017 indicating that you had gross income of $426.40 for that pay period, and year-to-date income of $1,668.70. If the $426.40 is subtracted from the year-to-date total, it leaves $1,242.30, which would represent your gross monthly income for the month of January 2017 – the month in which you filed your application.

To be eligible for Medicaid based on monthly income, 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 you earned $1,242.30 in January 2017, you may qualify for Medicaid on the basis of monthly income, as of the date of your application.

Therefore, since the record now contains documentation of your January 2017 income, your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid on the basis of monthly income for a household of one with a gross monthly income of $1,242.30, residing in Suffolk County, effective February 1, 2017.

Decision

The January 11, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid based on a one-person household with a monthly income of $1,242.30, residing in Suffolk County, effective February 1, 2017, or a later date of your choosing.

Effective Date of this Decision: May 15, 2017

How this Decision Affects Your Eligibility

The January 11, 2017 eligibility determination correctly found you eligible for the Essential Plan with a $20.00 monthly premium, based on your expected annual income.

However, your case is being sent back to NYSOH to redetermine your eligibility for Medicaid coverage based on the information you provided during your hearing.

Should you be determined eligible for Medicaid, your coverage can begin as early as February 1, 2017.

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 11, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for Medicaid based on a one-person household with a monthly income of $1,242.30, residing in Suffolk County, effective February 1, 2017, or a later date of your choosing.

The January 11, 2017 eligibility determination correctly found you eligible for the Essential Plan with a $20.00 monthly premium, based on your expected annual income.

However, your case is being sent back to NYSOH to redetermine your eligibility for Medicaid coverage based on the information you provided during your hearing.

Should you be determined eligible for Medicaid, your coverage can begin as early as February 1, 2017.

Legal Authority

We are sending you this notice 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.

□□□□□ (Bengali)

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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 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)

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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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