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

Notice of Decision

Decision Date: August 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016682

[redacted]

[redacted],

On June 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 24, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: August 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016682

Issues

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

> Did NY State of Health properly determine you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective March 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid, as of February 28, 2017?

Procedural History

On January 23, 2017, NY State of Health (NYSOH) received your updated application for financial assistance.

On January 24, 2017, NYSOH issued an eligibility determination notice stating were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective March 1, 2017. The notice indicated you were no longer eligible for Medicaid as of February 28, 2017.

On January 24, 2017, NYSOH issued a notice of enrollment confirmation stating you were enrolled in an Essential Plan with a $20.00 monthly premium, effective March 1, 2017.

On March 8, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the January 24, 2017 eligibility determination insofar as you were not eligible for Medicaid.

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On March 14, 2017, you were found eligible for Aid to Continue and you were enrolled in a Medicaid Managed Care plan, effective April 1, 2017, pending the outcome of your appeal.

Also on March 14, 2017, NYSOH issued a notice of disenrollment stating your coverage through your Essential Plan was terminated, effective March 31, 2017.

On June 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was left open until July 6, 2017 to allow you to submit supporting documentation.

On June 27, 2017 and on July 6, 2017, NYSOH Appeals Unit received your supporting documentation. The documents were incorporated into the record as Appellant's Exhibit #1 and the record closed thereafter.

Findings of Fact

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

1) You are seeking insurance for yourself.

2) An updated application was submitted on your behalf on January 23, 2017. That application indicated your household income for 2017 was $19,000.00. You testified that amount was accurate.

3) Your application indicated that you intend to file your 2017 taxes with a tax filing status of single and you will claim no dependents on that tax return. You testified that information is accurate.

4) Your previous application, submitted on March 17, 2016, listed the same household income amount, but indicated you were claiming one child as a dependent on your 2016 tax return. You were found eligible for Medicaid based on that application.

5) You testified you will not claim your child as a dependent on your 2017 tax return.

6) You testified you have one part-time job and you are paid weekly. You testified your weekly paycheck is always the same.

7) You were directed to submit proof of your income for the month of January 2017. On June 27, 2017 and again on July 6, 2017, NYSOH received a copy of the following weekly paystubs:

a. Paystub with check date of January 13, 2017 in the gross amount of $382.16 with a year to date amount of $744.86.

b. Paystub with check date of January 20, 2017 in the gross amount of $364.51.

c. Paystub with check date of January 27, 2017 in the gross amount of $362.70 with a year to date amount of $1,835.74.

d. Paystub with check date of February 3, 2017 in the gross amount of $363.67.

8) Based on the information in the January 23, 2017 application, NYSOH determined you eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective March 1, 2017. You were no longer eligible for Medicaid.

9) You enrolled in an Essential Plan, effective March 1, 2017.

10) You were granted Aid to Continue in your Medicaid Managed Care plan and you were disenrolled from your Essential Plan, effective March 31, 2017, and enrolled into a Medicaid Managed Care plan, effective April 1, 2017, pending the outcome of your appeal.

11) You testified you are appealing your eligibility insofar as you are no longer eligible for Medicaid.

12) You testified that you have a medical condition requiring medication and treatment and you are not sure such treatment will be covered under the Essential Plan. You testified that it is medically necessary that you be eligible for Medicaid as a result of your medical condition.

13) In support of your contention, you submitted medical documentation establishing that you have a medical condition requiring regular treatment as well as a “Disability Questionnaire” from the Department of Health. You also submitted an incomplete copy of a Decision After Fair Hearing based on Stipulation issued by the New York State Office of Temporary and Disability Assistance issued January 14, 2015. The decision is missing the second page and does not contain any information concerning the disposition of the matter.

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 Federal Register 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).

NYSOH is required to refer an individual who is not eligible for MAGI-based Medicaid because they are in receipt of Medicare, certified disabled, or over the age of 65 to the Local Department of Social Services or the Human Resources Administration. During the referral process, an individual's Medicaid eligibility, including their enrollment in a Medicaid Managed Care plan or receipt of Premium Payment Assistance, continues until such a time as their eligibility can be redetermined on a non-MAGI Medicaid basis (*see generally* 42 CFR § 435.1200, 42 CFR § 435.930, 14 OHIP/LCM-2 effective as of December 1, 2014, GIS 16 MA/04 effective as of January 1, 2016).

Legal Analysis

The first issue under review is whether NYSOH properly determined you were eligible for the Essential Plan with a $20.00 monthly premium, effective March 1, 2017.

The updated application submitted on your behalf on January 23, 2017 indicated your household income for 2017 was $19,000.00, that you would be filing your 2017 taxes with a tax filing status of single and you would claim no dependents on that tax return. Additionally, your application indicated that you will take no deductions on your 2017 tax return. You testified the information in your application was accurate and the subject eligibility determination relied upon that information.

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 $19,000.00 is 159.93% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

Pursuant to the regulations, applications with a household income greater than 150% of the FPL or below 200% of the FPL, must pay a $20.00 per month premium contribution for the Essential Plan. Since your household income for

2017 is 159.93% of the applicable FPL, NYSOH properly determined you were eligible for the Essential Plan with a $20.00 monthly premium.

The second issue 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 $19,000.00 is 159.93% 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.

Although you only submitted three weekly paystubs with check dates in January 2017, the year-to-date amount listed on the January 27, 2017 paystub establishes that you earned $1,835.74 in January 2017.

To be eligible for Medicaid through NYSOH, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,367.00.00 per month. Since the documentation you provided shows that you earned $1,835.74 in January 2017 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the January 24, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan with a $20.00 monthly premium and ineligible for Medicaid, it is correct and is AFFIRMED.

It is noted that although you contended that it is medically necessary that you continue in your Medicaid Managed Care plan due to a diagnosed medical condition, medical necessity is not a factor considered by the Appeals Unit in determining an applicant's eligibility for MAGI-based Medicaid offered through NYSOH. Although the regulations require NYSOH to refer an individual who is not eligible for MAGI-based Medicaid because they are in receipt of Medicare, certified disabled, or over the age of 65, to the Local Department of Social Services or the Human Resources Administration, there is insufficient evidence in the record to establish that you are not eligible for MAGI-based Medicaid for these reasons. While you submitted a "Disability Questionnaire," that document does not indicate that you have been determined "certified disabled." Accordingly, the aforementioned referral requirements are inapplicable to the present case.

Decision

The January 24, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: August 21, 2017

How this Decision Affects Your Eligibility

This decision does not change 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 June 3, 2016 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

You remain eligible for the Essential Plan.

You are not eligible for Medicaid.

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.

বাংলা (Bengali)

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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।

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.

(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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