



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

Notice of Decision

Decision Date: July 25, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017438

[REDACTED]

Dear [REDACTED]

On July 6, 2017, you and your spouse, acting as your Authorized Representative, appeared by telephone at a hearing on your appeal of NY State of Health's March 29, 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.

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.



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

Decision

Decision Date: July 25, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017438

[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, effective May 1, 2017?

Did NYSOH properly determine that you were ineligible for Medicaid?

Procedural History

On December 5, 2016, NYSOH issued a notice confirming that your Medicaid coverage through [REDACTED] Department of Social Services would end on February 28, 2017. The notice stated that a NYSOH account had been created for you and advised you to update your account between January 16, 2017 and February 15, 2017 to complete the renewal process.

On March 7, 2017, NYSOH received your initial application for financial assistance.

On March 8, 2017, NYSOH issued a notice confirming that your March 7, 2017 application had been reviewed, but the information contained in the application did not match what NYSOH received from state and federal data sources. The notice requested that you provide income documentation for your household by March 22, 2017.

On March 10, 2017, NYSOH received a facsimile containing four earnings statements issued to you by your employer, [REDACTED] between January 20, 2017 and March 3, 2017.

On March 28, 2017, NYSOH issued a notice confirming receipt of the income documentation you provided. However, the notice also stated that you currently had an application change in progress that you needed to complete before your household's eligibility could be determined.

Also on March 28, 2017, NYSOH received an update to your application for health insurance. In response to that application, NYSOH prepared a preliminary eligibility determination stating that you were eligible for the Essential Plan at no monthly premium, effective May 1, 2017.

Also on March 28, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not eligible for Medicaid.

On March 29, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with no month premium, effective May 1, 2017.

Also on March 29, 2017, NYSOH issued an enrollment notice confirming your selection of an Essential Plan as of March 28, 2017. The notice confirmed that your Essential Plan coverage would begin effective May 1, 2017.

On April 24, 2017, NYSOH received two additional earnings statements (not previously provided on March 10, 2017) issued to you by your employer on March 17, 2017 and March 31, 2017.

On July 6, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: a copy of your 2016 tax return. The record was to be closed 15 days after the hearing date, or upon the receipt of the above referenced documents, whichever occurred earlier. No additional documents were received from you by July 21, 2017.

Accordingly, the record was closed on July 21, 2017.

Findings of Fact

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

- 1) You testified that you wanted your spouse, [REDACTED], to act as your Authorized Representative during the hearing.
- 2) Your NYSOH application reflects that you do not expect to file a tax return for 2017, and that your spouse expects to file a tax return for 2017 with a tax filing status of head of household, claiming your child as [REDACTED] dependent. During the hearing, however, your spouse testified that [REDACTED] anticipates filing as head of household and claiming both you and your child as dependents on [REDACTED] 2017 tax return.
- 3) Your spouse testified that [REDACTED] filed [REDACTED] 2016 tax return as head of household, while claiming both you and your child as dependents, though no copy of your 2016 tax return was provided to NYSOH to corroborate that testimony.
- 4) Your spouse testified that you are currently seeking to be certified disabled by the Social Security Administration, but that has not yet occurred.
- 5) You were appealing only your own eligibility since you were seeking Medicaid coverage beginning March 1, 2017 since it was ended through [REDACTED] Department of Social Services as of February 28, 2017.
- 6) The application that was submitted on March 28, 2017, which requested financial assistance, listed annual household income of \$29,758.68, consisting of \$2,333.89 your spouse earns from [REDACTED] employment with [REDACTED]. Your spouse testified that this amount was correct when provided on March 28, 2017.
- 7) On March 10, 2017, you provided four earnings statements reflecting that your spouse received (1) \$1,231.14 on January 20, 2017, (2) \$1,107.75 on February 3, 2017, (3) \$1,316.44 on February 17, 2017, and (4) \$1,218.01 on March 3, 2017.
- 8) On April 24, 2017, you provided two additional earnings statement reflecting that you received (1) \$1,157.64 on March 17, 2017, and (2) \$1,161.57 on March 31, 2017.
- 9) Your application states that you will not be taking any deductions on your 2017 tax return.
- 10) You live in [REDACTED], New York.
- 11) Your spouse testified that you were seeking Medicaid coverage beginning March 1, 2017 since you had medical conditions that required greater coverage that was not provided through the Essential Plan.

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 \$20,160.00 for a three-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).

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)).

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).

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 2017 FPL, which is \$20,420.00 for a three-person household (82 Fed. Reg. 8831).

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 May 1, 2017.

The application that was submitted on March 28, 2017 listed an annual household income of \$29,758.68, consisting of \$2,333.89 your spouse earns from [REDACTED] employment with [REDACTED]. The eligibility determination relied upon that information.

While your NYSOH application reflects that you do not anticipate filing taxes for 2017, since you reside with your spouse and your child, they are included as part of your household. Furthermore, your spouse testified that [REDACTED] anticipated claiming both you and your child as dependents on [REDACTED] 2017 tax return. In either case, you are in a three-person household.

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 \$20,160.00 for a three-person household. Since an annual household income of \$29,758.68 is 147.61% 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 ineligible 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 \$20,420.00 for a three-person household. Since \$29,758.68 is 145.73% of the 2017 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.

Between March 10, 2017 and April 24, 2017, you provided three earnings statements issued to your spouse reflecting that [REDACTED] received a total of \$3,537.22 from her employer during the month of your application, March 2017.

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 \$2,348.00 per month. Since the documentation you provided shows that your household received \$3,537.22 in during March 2017, you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the March 29, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for the Essential Plan, and ineligible for Medicaid, it was correct and is AFFIRMED.

Decision

The March 29, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: July 25, 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.

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).

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 March 29, 2017 eligibility determination notice is **AFFIRMED**.

You remain eligible for the Essential Plan.

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).

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:



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 مجاناً.

বাংলা (Bengali)

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).

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ 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 کرم 1-855-355-5777 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 איר געבן א דאלמענטשער 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).

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).