



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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000018812

[REDACTED]

Dear [REDACTED],

On August 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 27, 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 the NY State of Health number 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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Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000018812



Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health (NYSOH) properly determine that you were not eligible for health insurance coverage as of April 30, 2017?

Procedural History

On September 13, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, effective as of October 1, 2016.

Also on September 13, 2016, NYSOH issued a plan enrollment notice confirming that as of September 12, 2016, you were enrolled in an Essential Plan with an enrollment start date of October 1, 2016.

On April 14, 2017, your account was systematically updated.

On April 15, 2017, NYSOH issued an eligibility determination notice stating that you did not qualify for: Medicaid, the Essential Plan, tax credits or cost-sharing reductions, and could not enroll in a qualified health plan through NYSOH, effective May 1, 2017. The notice further stated that you did not qualify for health insurance through NYSOH because federal and state data sources indicated that you were enrolled in Medicare.

Also on April 15, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end April 30, 2017, because you were no longer eligible to enroll in health insurance coverage through NYSOH.

On April 26, 2017, your account was updated.

On April 27, 2017, NYSOH issued an eligibility determination notice stating that you did not qualify for Medicaid, the Essential Plan, tax credits or cost-sharing reductions, and could not enroll in a qualified health plan through NYSOH. The notice stated that you did not qualify for health insurance through NYSOH because federal and state data sources indicated that you were enrolled in Medicare.

On May 9, 2017, you contacted NYSOH's Account Review Unit and requested an appeal relative to being determined ineligible for health insurance through NYSOH.

On August 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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) According to your NYSOH account and testimony, you are applying for health insurance for yourself.
- 2) You testified that you expect to file your 2017 federal income tax return with the tax status of single and do not expect to claim any dependents on that tax return.
- 3) According to your NYSOH account, you have been enrolled in Medicare since April 1, 2017.
- 4) You testified that you are enrolled in Medicare Parts A and B.
- 5) You testified that you are issued approximately \$1,500.00 monthly in Social Security Disability Insurance benefits.
- 6) According to your NYSOH account, you reside in [REDACTED].
- 7) You testified that you have applied for health insurance through [REDACTED] Local Department of Social Services, but have not received an eligibility determination.

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

Applicable Law and Regulations

Qualified Health Plan

It is unlawful for a person to sell or issue to an individual, entitled to benefits under Medicare Part A or enrolled under Medicare Part B, a health insurance policy with the knowledge that the policy duplicates health benefits to which the individual is otherwise entitled to be enrolled in (42 U.S. Code § 1395ss(d)(3)(A); https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf (last updated April 28, 2016)).

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).

Minimum essential coverage includes most government-sponsored insurance plans such as Medicaid, Medicare, CHIP, Tricare, Veterans' Health Coverage, and eligible employer-sponsored insurance (26 USC §§ 36B(c)(2)(B) and 5000A(f)).

Medicaid

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

In general, to qualify for MAGI-based Medicaid through NYSOH, you must also be one of the following:

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- An adult aged 19-64 who is not eligible for Medicare Part A or Part B,
- A pregnant woman or infant,
- A child aged 1-18, or
- A parent or caretaker relative

(45 CFR § 155.305(c); N.Y. Soc. Serv. Law § 366(1)(b)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (see N.Y. Soc. Serv. Law § 366(1)(c)).

Legal Analysis

The issue under review is whether you were properly determined ineligible for health insurance through NYSOH.

The sale or issuance of duplicate health insurance coverage to Medicare beneficiaries, including qualified health plans through NYSOH, is prohibited. The record reflects that you have been enrolled in Medicare Parts A and B since [REDACTED]. Therefore, you were not eligible to enroll in a qualified health plan at full cost through NYSOH.

The Essential Plan is available to individuals who are not otherwise eligible for minimum essential coverage. Various government-sponsored plans provide minimum essential coverage, including Part A of the Medicare program. Again, since you have been enrolled in Medicare Parts A and B since [REDACTED], you were not eligible to enroll in the Essential Plan because you were enrolled in minimum essential coverage.

Medicaid through NYSOH (called MAGI-based Medicaid) is available to individuals who are between the ages of 19 and 64, who are not eligible for Medicare Parts A or B; pregnant women or infants; children between the ages of 1 and 18; and parent or caretaker relatives.

The record reflects that, when NYSOH issued the April 27, 2017 eligibility determination, you were eligible for and enrolled in Medicare Parts A and B. Furthermore, the record reflects that you have no dependents and, therefore, are not a parent or a caretaker relative of a dependent child such that you would qualify on this basis.

Since you were enrolled in Medicare and not a parent or caretaker relative, NYSOH properly determined that you were not eligible for Medicaid through NYSOH.

Therefore, you were properly determined ineligible to enroll in health insurance through NYSOH, and the April 27, 2017 eligibility determination notice to his effect is AFFIRMED.

Decision

The April 27, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: August 24, 2017

How this Decision Affects Your Eligibility

You are not eligible for health insurance through NYSOH.

Your coverage in the Essential Plan through NYSOH ended April 30, 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.

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).

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 April 27, 2017 eligibility determination notice is AFFIRMED.

You are not eligible for health insurance through NYSOH.

Your coverage in the Essential Plan through NYSOH ended April 30, 2017.

Legal Authority

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

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 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&btumi ama wo obi a okyer& 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 אייך געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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