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

Notice of Decision

Decision Date: September 12, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000018903

[redacted]

Dear [redacted],

On August 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 3, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: September 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018903

[redacted]

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 the Essential Plan and eligible for Medicaid?

Procedural History

On February 3, 2017, you submitted an application for financial assistance to NYSOH.

On February 4, 2017, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for the Essential Plan with a $20.00 monthly premium, effective March 1, 2017. You were directed to provide income information by May 4, 2017.

Also on February 4, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in an Essential Plan, effective March 1, 2017.

On April 12, 2017, you uploaded income documentation to your NYSOH account.

On April 17, 2017, NYSOH redetermined your eligibility.

On April 18, 2017, NYSOH issued a disenrollment notice stating that you were disenrolled from the Essential Plan, effective May 31, 2017.

On May 2, 2017, NYSOH systematically redetermined your eligibility and submitted an application on your behalf for financial assistance.

On May 3, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective May 1, 2017. That notice also stated that you were eligible for Medicaid because your income of $15,258.88 was below the income limit for that program.

On May 11, 2017, you spoke to NYSOH's Account Review Unit and appealed your Medicaid eligibility insofar as you believe that based on your income, you are ineligible for Medicaid and eligible for the Essential Plan.

On May 13, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan with a start date of June 1, 2017.

On August 18, 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) 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) You are seeking insurance for yourself.

3) On April 12, 2016, NYSOH records reflect that you uploaded four consecutive pay stubs to your NYSOH account ( ).
    a. The pay stub with the 3/16/17 pay date indicates gross earnings of $285.00 and in the section "Other Items" lists $245.00 as " ."
    b. The pay stub with the 3/23/17 pay date indicates gross earnings of $305.63 and in the section "Other Items" lists $250.00 as " ."
    c. The pay stub with the 3/30/17 pay date indicates gross earnings of $277.50 and in the section "Other Items" lists $220.00 as "
    d. The pay stub with the 4/6/17 pay date indicates gross earnings of $305.63 and in the section "Other Items" lists $280.00 as " ."

4) The application that was submitted on May 2, 2017 listed annual household income of $15,258.88, consisting of $15,258.88 you earn from your employment.

5) Based on the pay stubs provided by you, your estimated expected gross annual income for 2017 including [redacted] is $26,025.12.

6) You testified, and NYSOH records reflect that you contacted NYSOH on May 11, 2017 and advised a NYSOH representative that you did not believe that NYSOH included your tips in your annual household income. You testified that a NYSOH representative stated that you would have to wait for an appeal to have the issue resolved.

7) You testified that you last updated your income information on February 3, 2017. You testified that you listed your expected annual income as $23,000.00 from your current employer. You testified that you believe that NYSOH lowered your household income to $15,258.00 because they did not include the amount you earn in tips which is listed on your pay stubs.

8) You testified that you have not scheduled any medical appointments since you were determined eligible for Medicaid because you do not believe that you are Medicaid eligible and are afraid of engaging in fraud.

9) Your application states that you will not be taking any deductions on your 2017 tax return.

10) Your application states that you live in [redacted].

11) You testified that you would like your 2017 household income to be correctly redetermined.

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).

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 2017 FPL, which is $12,060.00 for a one-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 issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan and eligible for Medicaid, effective May 1, 2017.

The eligibility determination that was submitted by NYSOH listed an annual income of $15,258.88 and the eligibility determination relied on 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.

You testified, and NYSOH records reflect that you contacted NYSOH on May 11, 2017 and advised a NYSOH representative that you did not believe that NYSOH included your tips in your annual household income. You testified that a NYSOH representative stated that you would have to wait for an appeal to have the issue resolved.

You testified that you last updated your income information on February 3, 2017. You testified that you listed your expected annual income as $23,000.00 from your current employer. You testified that you believe that NYSOH lowered your household income to $15,258.00 because they did not include the amount you earn in tips which is listed on your pay stubs.

Based on the pay stubs provided by you, your expected 2017 gross annual income including tips is $26,025.12.

Since the May 3, 2017 eligibility determination was based on incorrect information, it is RESCINDED and your case is being RETURNED to NYSOH to redetermine your eligibility based on being in a one-person household with an annual household income of $26,025.12 and residing in [redacted]

Decision

The May 3, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your eligibility based on being in a one-person household with an annual household income of $26,025.12 and residing in [redacted]

Effective Date of this Decision: September 12, 2017

How this Decision Affects Your Eligibility

Your case is being RETURNED to NYSOH to redetermine your eligibility based on being in a one-person household with an annual household income of $26,025.12 and residing in [redacted].

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

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The May 3, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your eligibility based on being in a one-person household with an annual household income of $26,025.12 and residing in [redacted]

Legal Authority

We are sending you this notice in accordance with 45 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).

A Copy of this Decision Has Been Provided To:

[redacted]

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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।

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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 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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