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

Notice of Decision

Decision Date: October 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019261

[redacted]

Dear [redacted],

On September 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 5, 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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Decision Date: October 20, 2017

NY State of Health Account ID: [redacted]
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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 for the Essential Plan, effective June 1, 2017?
>
> Did NY State of Health properly determine you were not eligible for Medicaid, effective June 1, 2017?

Procedural History

On May 4, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf.

On May 5, 2017, NYSOH issued a notice of eligibility determination stating you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective June 1, 2017.

Also on May 5, 2017, NYSOH issued an enrollment notice confirming you were enrolled in an Essential Plan, effective June 1, 2017.

On May 25, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were no longer eligible for Medicaid.

On June 2, 2017, NYSOH issued an eligibility determination stating you had been granted aid to continue in your Essential Plan pending the decision in your

appeal. You were reenrolled in your Medicaid Managed Care plan, effective June 1, 2017.

Also on June 2, 2017, NYSOH issued a notice confirming your enrollment in the Essential Plan had been cancelled, effective June 1, 2017.

On September 7, 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 were determined eligible for Medicaid, effective May 1, 2016, based on a May 19, 2016 application listing your annual income as $9,620.00.

2) On May 4, 2017, you updated your application for the 2017 coverage year. The application submitted that day listed your annual income for 2017 as $20,000.00. The application indicated that this income was earned from employment you would have between January 1, 2017 and May 19, 2017.

3) You testified that you worked 18 weeks at [redacted] between January 2, 2017 and May 19, 2017. You testified that you earned $20.00 an hour and worked, on average, 40 hours a week. You testified that you subsequently added up all your paystubs and you earned $17,249.75 in gross income at that position for 2017.

4) You testified that you have not worked since May 19, 2017.

5) You testified you were paid for three weeks in May 2017 and you earned a gross total of $2,934.75 in that month.

6) You testified that you began collecting unemployment insurance benefits in August 2017 in the gross amount of $430.00 weekly. You have not submitted documentation to verify this income.

7) You testified that you are seeking eligibility for Medicaid, because you are no longer working and you cannot afford the Essential Plan. You testified that you never wanted to be enrolled in the Essential Plan, you were enrolled without your knowledge, and you were told you could not cancel your enrollment.

8) According to your account, you were enrolled in an Essential Plan, effective June 1, 2017, but that enrollment was cancelled when you were

reenrolled in your Medicaid Managed Care plan, effective June 1, 2017, pursuant to a grant of "Aid to Continue" pending your appeal.

9) According to your account, you have not updated your application since May 4, 2017.

10) You testified, and your application indicates, you expect to file your 2017 taxes with a tax filing status of single and you will claim no dependents.

11) You testified, and your application indicates, you will not take any deductions on your 2017 tax return.

12) You testified, and your application indicates, you live in Queens County.

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

On May 4, 2017, you updated your application for the 2017 coverage year. The application submitted that day listed your annual income for 2017 as $20,000.00. Although you testified that you subsequently added up the paystubs that you received from your employer and determined that you actually only earned $17,249.75 at that position, the subject eligibility determination relied upon the information you provided in the May 4, 2017 application. Thus, this review is based on the information in that application.

The evidence establishes that you are in a one-person household, because you will file your 2017 tax return with a tax filing status of single and you will claim no dependents.

Pursuant to the regulations, the Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. 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.

On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $20,000.00 is 168.35% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan with a $20.00 monthly premium.

It is noted that according to your account, you were enrolled in an Essential Plan, effective June 1, 2017. You testified that you never wanted to be enrolled in the Essential Plan, you were enrolled without your knowledge, and you were told you could not cancel your enrollment. However, your account confirms your Essential Plan enrollment was cancelled when you were reenrolled in your Medicaid Managed Care plan, effective June 1, 2017, pursuant to a grant of aid to continue.

The second issue under review is whether NYSOH properly determined you were no longer eligible for Medicaid, effective June 1, 2017.

As discussed above, your May 4, 2017 application indicated your annual income for 2017 was $20,000.00 and the subject eligibility determination relied upon that information.

Pursuant to the regulations, 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 $12,060.00 for a one-person household. Since $20,000.00 is 165.83% of the 2017 FPL, NYSOH properly found you 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.

You testified that you were paid for three weeks in May 2017 and earned $2,934.75 in gross income in that month.

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 $1,387.00 per month. Since, based on your own testimony, you earned $2,934.75 in May 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the May 5, 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.

However, you testified you have been unemployed since May 19, 2017 and that you have been receiving unemployment insurance benefits in the gross amount of $430.00 per week since August 2017. Notwithstanding this, your application has not been updated to reflect the change in your income.

Even assuming you have or will received unemployment benefits of $430.00 per week from August 7, 2017 to the end of the year, and that you have not worked in any capacity since that time, this would add 21 weeks of benefits to your annual income, or an additional $9.030.00. This would result in annual anticipated earnings of $26,279.75, an amount well in excess of the allowable limit for both Medicaid and the Essential Plan.

Therefore, this case is returned to NYSOH to redetermine your eligibility for financial assistance based on expected annual income of $26,279.75 for 2017, subject to your verification of your unemployment benefits.

You are further reminded of your obligation to update your NYSOH application within 30 days of any change in income.

Decision

The May 5, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH for a redetermination of your eligibility based on the income to which you testified, $26,279.75, for a one-person household in Queens County.

Effective Date of this Decision: October 20, 2017

How this Decision Affects Your Eligibility

Your eligibility will be redetermined based on your testimony regarding your income.

You remain ineligible 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

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).

- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The May 5, 2017 eligibility determination notice is AFFIRMED.

Your case is returned to NYSOH for a redetermination of your eligibility based on the income to which you testified, $26,279.75, for a one-person household in Queens County.

You are ineligible 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:

[redacted]

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)

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।

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).

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)

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.

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).