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

Notice of Decision

Decision Date: October 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020152

[redacted]

Dear [redacted],

On September 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 1, 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 Account ID at the top of this notice.

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).

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: October 5, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020152

[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 and your spouse were no longer eligible for the Essential Plan and eligible for Medicaid through NYSOH as of August 1, 2017?

Procedural History

On July 21, 2016, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for the Essential Plan with a premium of $20.00 per month, effective September 1, 2016.

On June 30, 2017, you updated your and your spouse's application for financial assistance three times. That same day, a preliminary eligibility determination was prepared, finding in part, that you and your spouse were eligible for Medicaid as of June 1, 2017.

Also on June 30, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you and your spouse were no longer eligible for coverage through the Essential Plan.

On July 1, 2017, NYSOH issued an eligibility determination notice, based on the information contained in your and your spouse's June 30, 2017 updated application, stating that you and your spouse were no longer eligible for Medicaid, effective August 1, 2017. That notice further stated that NYSOH will continue Medicaid coverage until May 31, 2018.

Also on July 1, 2017, NYSOH issued a plan enrollment notice confirming that you and your spouse were enrolled in a Medicaid Managed Care plan effective August 1, 2017.

On July 4, 2017, NYSOH issued an eligibility determination notice, in which you and your spouse were granted Aid to Continue in your Essential Plan pending the outcome of your appeal. The July 4, 2017 plan enrollment notice restored your and your spouse's coverage in your Essential Plan for a limited time, effective August 1, 2017.

On September 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit.

The record was held open until October 6, 2017 for you to submit proof of your household income; specifically, your proof of your June 2017 and July 2017 gross household income, including any Individual Retirement Account (IRA) distributions, Dividends, and Capital Gains income.

On September 21, 2017, the Appeals Unit received your August monthly paystub and a statement of your 2017 IRA distributions and, on October 1, 2017, a statement of your 2017 IRA distributions, a bank statement reflecting the date of your IRA distribution, and your June 2017 and July 2017 monthly paystubs. These documents were made part of the record as "Appellant's Exhibit A" and "Appellant's Exhibit B," respectively. Since you submitted all required documentation as of October 1, 2017, the record was closed that day.

Findings of Fact

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

1) According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself and your spouse.

3) The initial application that was submitted on June 30, 2017 listed an annual household income of $18,450.00, consisting of $1,650.00 you earn from your employment, $7,500.00 in Social Security benefits you receive, plus $5,000.00 in capital gains income, and $4,300.00 your spouse earns from her employment. You testified that these amounts were incorrect and that your annual household income is expected to be $25,450.00 for 2017.

4) The final application that was submitted on June 30, 2017 listed annual household income of $25,450.00, consisting of $1,650.00 you earn from your employment, $7,500.00 in Social Security benefits you receive, plus $12,000.00 in capital gains income, and $4,300.00 your spouse earns from her employment. You testified that the expected year-to-date income was correct except that you expected $7,000.00 in a gross distribution of your IRA and $5,000.00 in capital gains income as opposed to $12,000.00 in capital gains income.

5) You testified that your monthly household income between April 2017 through June 2017 will reflect close to $0.00 for those months because that was before you began receiving your Social Security retirement benefits in July 2017. You further testified that your spouse received her last paycheck, [redacted], in or around April 2017. Since then and through June 2017, you and your spouse lived off your savings and your [redacted] income of $135.00 per month.

6) You testified that you will receive a $7,000.00 lump sum IRA distribution in the month of September 2017. You further testified that you have dividends and capital gains income of approximately $5,000.00 but that you expect to receive that in December 2017. On October 1, 2017, you submitted a statement of 2017 IRA distributions and a bank statement. These statements show that you received a distribution in 2017 in the amount of $7,000.00 on September 5, 2017(*see* Appellant's Exhibit B, pp. 2-4).

7) You also submitted your monthly paystubs dated June 8, 2017 and July 13, 2017. These paystubs show that you received $143.51 in employment income in both months (*see* Appellant's Exhibit B, pp. 3-4).

8) You testified that you prefer the Essential Plan, but if you are found eligible for Medicaid that is acceptable.

9) According to the Eligibility History tab in your NYSOH account, you and your spouse were found eligible for Medicaid as of June 1, 2017.

10) According to your NYSOH account, you and your spouse live in [redacted], New York.

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 noncitizen 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 $16,240.00 for a two-person household (81 Federal Register 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 $16,240.00 for a two-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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your spouse were no longer eligible for Essential Plan and eligible for Medicaid through NYSOH as of June 1, 2017.

The initial application that was submitted on June 30, 2017, listed an annual household income of $18,450.00, consisting of $1,650.00 you earn from your employment, $7,500.00 in Social Security benefits you receive plus $5,000.00 in capital gains income, and $4,300.00 your spouse earns from her employment. This information was relied upon by NYSOH when it redetermined your and your spouse's eligibility for financial assistance for the upcoming policy period.

You testified that this income information was incorrect and that the income information attested to in your final June 30, 2017 application of $25,450.00 is an accurate reflection of your and your spouse's expected 2017 gross annual household income, which includes an expected lump sum distribution from your IRA, plus your expected dividends and capital gains.

However, regardless of whether NYSOH improperly determined your expected 2017 annual household income to be $18,850.00, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits can also be based on current monthly household income and family size.

You credibly testified and submitted proof of income for the month of June 2017, which shows that you and your spouse received a total monthly gross household income of $143.51 (*see* Appellant's Exhibit B, pp. 2-4).

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 in 2017 is $1,868.00 per month for a to-person household. Since the documentation you provided shows that you and your spouse earned $143.51 in June 2017, you both qualified for Medicaid based on monthly income as of the date of your application.

Since the July 1, 2017 eligibility determination notice properly stated that you and your spouse were eligible for Medicaid, it is correct and is AFFIRMED.

Your case is RETURNED to NYSOH to restore your and your spouse's coverage in a Medicaid Managed Care plan as soon as is practicable and so as to ensure there is no gap in health insurance coverage.

Decision

The July 1, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to restore your and your spouse's coverage in a Medicaid Managed Care plan as soon as is practicable and so as to ensure there is no gap in health insurance coverage.

Effective Date of this Decision: October 5, 2017

How this Decision Affects Your Eligibility

Your and your spouse's eligibility does not change by this Decision.

You and your spouse were no longer eligible for the Essential Plan.

You and your spouse were eligible for Medicaid as of June 1, 2017.

Your case is being sent back to NYSOH to put you and your spouse back into a Medicaid Managed Care plan as soon as possible and in such a way that there is no gap in coverage when you are both transitioned out of Aid to Continue from the Essential Plan.

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 July 1, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to restore your and your spouse's coverage in a Medicaid Managed Care plan as soon as is practicable and so as to ensure there is no gap in health insurance coverage.

Your and your spouse's eligibility does not change by this Decision.

You and your spouse were no longer eligible for the Essential Plan.

You and your spouse were eligible for Medicaid as of June 1, 2017.

Your case is being sent back to NYSOH to put you and your spouse back into a Medicaid Managed Care plan as soon as possible and in such a way that there is no gap in coverage when you are both transitioned out of Aid to Continue from the Essential Plan.

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]

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.

한 국 어 (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.

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).

□□□□□ (Bengali)

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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 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.

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).

(Yiddish) אידיש

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).