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

Notice of Decision

Decision Date: January 09, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020822

[redacted]

[redacted]

On December 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 19, 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 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: January 09, 2018

NY State of Health Account ID: AC0001791896
Appeal Identification Number: AP000000020822

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health properly determine that you were eligible for Medicaid effective July 1, 2017?
>
> Did NY State of Health properly determine that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until June 30, 2018?

Procedural History

On July 18, 2017, NY State of Health (NYSOH) received your updated application for financial assistance.

On July 19, 2017, NYSOH issued an eligibility determination notice based on the July 18, 2017 updated application, stating that you were eligible for Medicaid, effective July 1, 2017. That notice also stated that you were eligible for Medicaid because your income of $13,600.00 was below the income limit for that program.

Also on July 19, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a Medicaid Managed Care plan, with a plan enrollment start date of September 1, 2017.

On July 25, 2017, you contacted NYSOH's Account Review Unit and appealed Medicaid eligibility finding, requesting your eligibility be redetermined for the Essential Plan.

On July 26, 2017, you submitted an updated application for financial assistance and changed your expected annual income to $18,000.00.

On July 27, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for Medicaid. However, your Medicaid coverage would continue until June 30, 2018 because certain individuals determined eligible for Medicaid remain eligible for benefits for 12 continuous months from the date that they were determined eligible. This eligibility was effective as of September 1, 2017.

On September 15, 2017, 2017, NYSOH issued a notice stating you were eligible for the Essential Plan for a limited time. You were granted Aid to Continue until a decision was made on your appeal, effective September 1, 2017.

Also on September 15, 2017, NYSOH issued an enrollment notice confirming your enrollment in an Essential Plan, effective September 1, 2017.

On October 16, 2017, you had a scheduled hearing with a Hearing Officer from NYSOH's Appeals Unit. The Hearing Officer was unable to reach you for that scheduled hearing and your appeal was dismissed for failure to appear.

On October 19, 2017, you submitted a request to vacate the dismissal based on good cause. Your request was granted and on December 5, 2017 you had a telephone hearing with the Hearing Officer. The record was developed during the hearing and held open until December 20, 2017 to allow you to submit supporting documentation.

On December 11, 2017 and on December 19, 2017 documentation you mailed was received and uploaded to your NYSOH account. Those documents have been marked as Appellant's Exhibit # 1 and Appellant's Exhibit # 2 respectively. The record was closed as of December 19, 2017.

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) The application that was submitted on July 17, 2017, which requested financial assistance, listed annual household income of $13,600.00, consisting of $10,400.00 you earn from your employment and $3,200.00 in

unemployment insurance benefits. You testified that this income was not an accurate representation of your household income.

4) You testified that at the time of your July 17, 2017 application you had not accurately estimated your income for the year from employment at [redacted]

5) You testified that you called NYSOH back on July 26, 2017 when you realized that the income you estimated from employment at [redacted] was incorrect.

6) According to your NYSOH account and your testimony, on July 26, 2017 you updated your account. In that application, you attested to an expected annual income of $18,000.00. You testified that this was an accurate estimate of your expected 2017 income based on your seasonal employment at [redacted]. and unemployment insurance benefits that you expected to receive in the winter months.

7) You testified that you were laid off from [redacted]. as of November 10, 2017 and will be collecting $210.00 weekly in unemployment insurance benefits.

8) You testified that your 2016 income tax return would be representative of your 2017 income.

9) You submitted a copy of your 2016 income tax return which reflects $14,880 in wages and $3,286.00 in unemployment compensation for a total adjusted gross income of $18,166.00 (*see* Document [redacted]).

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

11) According to your NYSOH account and your testimony you 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 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* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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 issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan and eligible for Medicaid, effective July 1, 2017.

The application that was submitted on July 18, 2017 listed an annual household income of $13,600.00 and the eligibility determination relied upon 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.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 64 who meet the non-financial requirements and have a household MAGI that is at or below 138% of the FPL for the applicable family size. On the date of your July 18, 2017 application, the relevant FPL was $12,060.00 for a one-person household. Since $13,600.00 is 112.77% of the 2017 FPL, NYSOH properly found you to be eligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, you testified the income listed on that July 17, 2017 application was not correct because you did not accurately estimate the income that you would make from your employment at [redacted]. which is seasonal in nature. You further testified that when you realized the mistake, On July 26, 2017 you called NYSOH and updated your application with an estimated annual income of $18,000.00. You submitted a copy of your 2016 income tax return which showed wages of $14,880.00 and $3,286.00 in unemployment insurance benefits for a total adjusted gross income in 2016 of $18,166.00. You testified that you expect your 2017 income to be about the same as 2016. You testified that you were laid off from [redacted] on November 10, 2017 and that you are now collecting unemployment insurance benefits of $210.00 a week.

Therefore, the evidence in the record reflects that your expected household income at the time of the July 18, 2017 application was $18,166.00. Since $18,166.00 is 150.06% of the 2017 FPL, it is greater than the allowable Medicaid limit, and the July 19, 2017 eligibility determination notice finding you eligible for Medicaid is not supported by the record and is RESCINDED.

The second issue is whether NYSOH properly determined that you were no longer eligible for Medicaid, but would continue to receive Medicaid coverage until June 30, 2018.

Once a person is found eligible for Medicaid, they remain eligible for Medicaid for 12 continuous months whether or not their income increases. This is referred to as “continuous coverage.”

Since the July 19, 2017 eligibility determination notice was issued based on incorrect information and is not supported by the record, the continuous coverage policy should not have been applied to you. Therefore, the July 27, 2017 eligibility determination notice is also RESCINDED.

Since the record now contains a more accurate representation of your expected annual household income, your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household, with an annual household income of $18,166.00 residing in [redacted], effective of July 1, 2017.

Decision

The July 19, 2017 and July 27, 2017 eligibility determination notices are 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 $18,166.00 and residing in [redacted], effective of July 1, 2017.

Effective Date of this Decision: January 09, 2018

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 $18,166.00 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.

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 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 19, 2017 and July 27, 2017 eligibility determination notices are 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 $18,166.00 and residing in [redacted], effective of July 1, 2017.

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:

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).