STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: December 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022402

[redacted]

Dear [redacted]

On November 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 12, 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
  PO 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(b).

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: December 21, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022402

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were eligible for the Essential Plan, effective October 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On August 2, 2017, NYSOH issued a renewal notice stating that you were newly eligible for the Essential Plan with a $20.00 monthly premium, effective October 1, 2017. This was because income information NYSOH obtained from state and federal data sources showed that your annual income was between $17,820.00 and $23,760.00.

On August 17, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in your Medicaid Managed Care plan was ending, effective September 30, 2017, because you were no longer eligible to enroll in Medicaid.

Also on August 17, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan, beginning October 1, 2017.

On September 8, 2017, you updated your NYSOH account and uploaded documentation to your account as well.

On September 9, 2017, NYSOH issued a notice stating that the income information in your application did not match information NYSOH received from state and federal data sources. The notice directed you to provide documentation of your income by September 23, 2017.

On September 9, 2017, NYSOH issued a notice stating that you would be disenrolled from your Essential Plan coverage, effective October 1, 2017, because you were no longer eligible to enroll in the Essential Plan.

On September 11, 2017, NYSOH reviewed the documentation you provided and redetermined your eligibility.

On September 12, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective October 1, 2017.

On September 13, 2017, you spoke to NYSOH's Account Review Unit and appealed, insofar as you were not eligible for Medicaid. You also requested Aid to Continue, pending the outcome of your appeal.

On September 17, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid for a limited time, effective October 1, 2017. This was because your request for Aid to Continue was granted, pending the outcome of your appeal.

Also on September 17, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Medicaid Managed Care plan, beginning October 1, 2017. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On November 22, 2017, you updated your NYSOH application, and indicated that you were pregnant and expecting one child in May 2018.

On November 23, 2017, NYSOH issued a notice of eligibility determination, stating that you were eligible for Medicaid, effective November 1, 2017.

Also on November 23, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Medicaid Managed Care plan, beginning October 1, 2017.

On November 30, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open through December 15, 2017, to allow you to submit supporting documents.

On December 1, 2017, you faxed documentation to the Appeals Unit. The record is now closed.

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 uploaded documentation to your NYSOH account on September 8, 2017, and NYSOH utilized that documentation to calculate your expected annual income.

3) NYSOH determined that your expected annual income for 2017 was $18,292.04, consisting of earned income.

4) You testified that you were not sure what your 2017 annual income would be, but that you earn $11.00 an hour, and work an average of 33 hours per week.

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

6) Your application states that you live in Queens County.

7) Your application was updated on November 22, 2017 to indicate that you were pregnant and expecting one child, with a due date of [redacted]. You testified that this is correct

8) You testified that you filed this appeal because you cannot afford the premium and copays associated with the Essential Plan.

9) After the hearing, you faxed two biweekly paystubs from the month of September 2017: one paystub is dated September 1, 2017, for gross pay of $702.90, and the second is dated September 15, 2017 for gross pay of $803.18. These documents are marked and entered into the record as "Appellant's Exhibit One."

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

Applicable Law and Regulations

<u>Essential Plan</u>

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 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, *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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 Federal Register 8831, 8832).

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).

Household Composition

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42

CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

FPL for Pregnant Women

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); NY Department of Health Administrative Directive 13ADM-03).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective October 1, 2017.

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. On the date of your application, the relevant FPL was $11,880.00 for a one-person household.

On September 8, 2017, you updated your application for financial assistance and uploaded income documentation to your account. NYSOH used this documentation to determine that your expected annual income for 2017 is $18,292.04. You testified that you are not sure of your exact expected income, but that you earn $11.00 an hour and work an average of 33 hours per week. This equates to an expected annual income of $18,876.00, which is generally consistent with NYSOH's calculation. You testified that you expect to file your 2017 income tax return as single, and will not claim any dependents.

Since an annual household income of $18,292.04 is 153.97% of the 2016 FPL, NYSOH properly found you eligible for the Essential Plan, based on the income documentation you provided, and the information in your September 8, 2017 application.

The second issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

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 $18,292.04 is 151.68% of the 2017 FPL, NYSOH

properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, on November 22, 2017, you updated your NYSOH application and indicated that you are pregnant and expecting one child with a due date of [redacted] As a result, you were found eligible for Medicaid, effective November 1, 2017.

Medicaid is currently available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size. Additionally, the household size of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver.

Since your NYSOH account indicates that your due date is [redacted], it was not correct for NYSOH to base your eligibility in September 2017 on a household of one, as you were pregnant in September. Additionally, you would have been eligible for Medicaid if your adjusted gross income was at or below 223% of the applicable FPL. On the date of your application, the relevant FPL was $16,240.00 for a household of two. Since $18,292.04 is 112.64% of the FPL for a household of two, you should have been eligible for Medicaid as of your September 8, 2017 application.

Therefore, although the September 12, 2017 eligibility determination was correct at the time it was issued, it is now MODIFIED to state that you were eligible for Medicaid, effective October 1, 2017.

The September 14, 2017 enrollment confirmation notice is MODIFIED to state that you were enrolled in your [redacted] Medicaid Managed Care plan, beginning October 1, 2017.

Decision

The September 12, 2017 eligibility determination notice is MODIFIED to state that you were eligible for Medicaid, effective October 1, 2017.

The September 14, 2017 enrollment confirmation notice is MODIFIED to state that you were enrolled in your Healthfirst Medicaid Managed Care plan, beginning October 1, 2017.

Effective Date of this Decision: December 21, 2017

How this Decision Affects Your Eligibility

You were eligible for Medicaid as of October 1, 2017.

Your enrollment in your Medicaid Managed Care plan should have started as of October 1, 2017.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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 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).

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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The September 12, 2017 eligibility determination notice is MODIFIED to state that you were eligible for Medicaid, effective October 1, 2017.

The September 14, 2017 enrollment confirmation notice is MODIFIED to state that you were enrolled in your [redacted] Medicaid Managed Care plan, beginning October 1, 2017.

You were eligible for Medicaid as of October 1, 2017.

Your enrollment in your Medicaid Managed Care plan should have started as of October 1, 2017.

Legal Authority

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

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 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.

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).