



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

Notice of Decision

Decision Date: January 10, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023799

[REDACTED]
[REDACTED],

On December 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 31, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: January 10, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023799



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 health insurance coverage as of October 31, 2017?

Procedural History

On October 30, 2017, NYSOH received your completed application for health insurance. That day, a preliminary eligibility determination was prepared regarding that application, stating that you did not qualify for health coverage through NYSOH.

Also on October 30, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to your ineligibility to obtain health insurance through NYSOH.

On October 31, 2017, NYSOH issued an eligibility determination notice based on the information contained in the October 30, 2017 application, stating that you were not eligible for health insurance through NYSOH. The notice stated that you were not eligible for Medicaid, the Essential Plan, advance payments of the premium tax credit, or cost-sharing reductions, or to purchase a qualified health plan at full cost through NYSOH. This was because federal and state data sources show that you were receiving Medicare and individuals enrolled in Medicare cannot receive health coverage through NYSOH. The notice also stated that you are not eligible for Medicaid because your income of \$71,627.80 is over the allowable limit of \$22,412.00.

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On December 21, 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 expected 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.
- 3) According to your NYSOH account and your testimony, you were found eligible for Medicaid Part A on December 1, 2015. You became eligible for Medicare because you were [REDACTED] through the Social Security Administration.
- 4) You testified that you were covered by your spouse's health insurance through his union until October 1, 2017 when that coverage ended.
- 5) According to your NYSOH account and your testimony, your date of birth is [REDACTED] and that you are currently [REDACTED].
- 6) According to your October 30, 2017 application, your household income is \$71,627.80 consisting of \$31,902.80 you receive from social security disability and wages from a part time position and \$39,725.00 your spouse receives in social security and wages from a part-time position he holds. You testified that this information is correct.
- 7) According to your NYSOH account and your testimony, you live in Suffolk County, New York.
- 8) You testified that you would like to be found eligible to obtain health insurance because Medicare Part A only covers hospitalization and you do not have coverage that would allow you to see a doctor at the present time.

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

Applicable Law and Regulations

Qualified Health Plan

It is unlawful for a person to sell or issue to an individual, entitled to benefits under Medicare Part A or enrolled under Medicare Part B, a health insurance policy with the knowledge that the policy duplicates health benefits to which the individual is otherwise entitled to be enrolled in (42 US Code § 1395ss(d)(3)(A); see https://www.cms.gov/Medicare/Eligibility-and-Enrollment/Medicare-and-the-Marketplace/Downloads/Medicare-Marketplace_Master_FAQ_4-28-16_v2.pdf (last updated April 28, 2016)).

Medicaid Eligibility

An individual is eligible for enrollment in Medicaid through NYSOH (called MAGI-based Medicaid) when he or she meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard (45 CFR § 155.305(c); NY Social Services Law § 366(1)(b)).

Medicaid can be provided through NYSOH to adults who meet the following non-financial criteria: (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 that is at or below 138% of the federal poverty level (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)).

If an individual does not fall into one of these categories, he or she may still be eligible for non-MAGI-based Medicaid coverage through their Local Department of Social Services or the New York City Human Resources Administration (see NY Social Services Law § 366(1)(c)).

Verification of Eligibility for the 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).

NYSOH must verify the eligibility of an applicant for the Essential Plan consistent with the standards set in 45 CFR § 155.315 and § 155.320 (New York's Basic Health Plan Blueprint, pgs. 16-17, as approved January 2016; see www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf); 42 CFR § 600.345(a)(2)).

An applicant is required to attest to their household's projected annual income. (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

Verification of Minimum Essential Coverage

NYSOH must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the BHP, using information obtained by transmitting identifying information specified by HHS to HHS for verification purposes (45 CFR § 155.330(b)).

Minimum essential coverage includes most government-sponsored insurance plans such as Medicaid, Medicare, CHIP, Tricare, Veterans' Health Coverage, and eligible employer-sponsored insurance (26 USC § 5000A(f)).

Minimum essential coverage includes coverage under the Medicare program under part A (26 USC § 5000A(f)(1)(A)(i)).

Legal Analysis

The issue under review is whether NYSOH properly determined you were ineligible for health insurance through NYSOH as of the October 31, 2017 eligibility determination.

The sale or issuance of duplicate health insurance coverage to Medicare beneficiaries, including qualified health plans through NYSOH, is prohibited. The record reflects that you have been enrolled in Medicare Part A since December 1, 2015. Therefore, you were not eligible to enroll in a qualified health plan at full cost through NYSOH.

The Essential Plan is available to individuals who are not otherwise eligible for minimum essential coverage. Various government-sponsored plans provide

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minimum essential coverage, including Part A of the Medicare program. Again, since you have been enrolled in Medicare Part A since December 1, 2015, you were not eligible to enroll in the Essential Plan because you were enrolled in minimum essential coverage.

To be eligible for MAGI-based Medicaid through NYSOH, a person cannot be entitled to or enrolled in Medicare Part A or B. You testified, and the record reflects that you have been enrolled in Medicare Part A since December 1, 2015. Furthermore, the record reflects that you have no dependents and, therefore, are not a parent or a caretaker relative of a dependent child. Therefore, you do not qualify on that basis.

The record reflects that, when NYSOH issued the October 31, 2017 eligibility determination notice, you were eligible for and enrolled in Medicare Part A. Therefore, you are not eligible for Medicaid through NYSOH.

Therefore, you were properly determined that you were not eligible to enroll in health insurance through NYSOH, and the October 31, 2017 eligibility determination notice is AFFIRMED.

NYSOH does not have the authority to decide if you qualify for non-MAGI-based Medicaid. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to the Suffolk County Department of Social Services to determine your eligibility for Medicaid or other Medicare programs.

Decision

The October 31, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 10, 2018

How this Decision Affects Your Eligibility

You do not qualify for MAGI-based Medicaid, the Essential Plan or to purchase a qualified health plan at full cost through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI based Medicaid. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to the Suffolk County Department of Social Services for consideration, if it has not already done so.

The Suffolk County Department of Social Services will determine your eligibility for Medicaid or other Medicare programs.

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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 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 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 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 October 31, 2017 eligibility determination notice is AFFIRMED.

You do not qualify for MAGI-based Medicaid, the Essential Plan or to purchase a qualified health plan at full cost through NYSOH.

NYSOH does not have the authority to decide if you qualify for non-MAGI based Medicaid. Since you may be eligible for Medicaid on a non-MAGI basis, NYSOH will refer your case to the Suffolk County Department of Social Services for consideration, if it has not already done so.

The Suffolk County Department of Social Services will determine your eligibility for Medicaid or other Medicare programs.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.