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

Notice of Decision

Decision Date: February 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024139

[redacted]

[redacted]

On January 23, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 8, 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
  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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
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Decision

Decision Date: February 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024139

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly cancel your Essential Plan coverage effective December 1, 2017, and begin your Medicaid coverage effective December 1, 2017?

Procedural History

On September 22, 2017, NYSOH issued a renewal and eligibility determination notice stating that you continued to qualify for health care coverage under the Essential Plan effective December 1, 2017.

On October 18, 2017, NYSOH issued an enrollment notice confirming your selection of an Essential Plan on October 17, 2017, with such coverage beginning effective December 1, 2017.

On November 7, 2017, NYSOH received an update to your application for financial assistance with health insurance, in which you reported being pregnant with one child. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you were eligible for Medicaid, effective December 1, 2017.

Also on November 7, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you had been found eligible for Medicaid, and were not permitted to remain enrolled in the Essential Plan. You were found eligible for "Aid to Continue" during the

pendency of the appeal, so you were reenrolled in the Essential Plan for a limited time.

On January 23, 2018, 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 initially enrolled in an Essential Plan effective December 1, 2017 based on a renewal eligibility determination issued by NYSOH on September 22, 2017.

2) Your NYSOH account confirms you contacted NYSOH on November 7, 2017, and your application was updated to report your pregnancy for the first time.

3) You testified, and your NYSOH account reflects, that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim your [redacted] child as your sole dependent on that tax return.

4) The application that was submitted on November 7, 2017 listed annual household income of $39,206.00, consisting of (1) $500.00 per week you receive from your employment with [redacted] (2) $5,406.00 you earned from your employment with [redacted] between January 1, 2017 and June 30, 2017, and (3) $7,800.00 your spouse earned from [redacted] between May 1, 2017 and December 1, 2017. You testified that these figures were reasonably accurate.

5) On that same day, your eligibility was redetermined with the updated information and you were determined eligible for Medicaid, effective December 1, 2017.

6) Your Essential Plan coverage was cancelled, effective December 1, 2017.

7) You testified that you are seeking reinstatement in your Essential Plan beginning December 1, 2017 since your current medical providers do not accept Medicaid, and you would prefer to remain with your current physicians due to your [redacted]

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

Applicable Law and Regulations

Changes in 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)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant to resolve the inconsistency (45 CFR §155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month (45 CFR § 155.420(b)(1)(i); *see also* 42 CFR § 600.320(c)). For updates received by NYSOH from the sixteenth to the last day of any month,

NYSOH must ensure coverage is effective the first day of the second following month (45 CFR § 155.420(b)(1)(ii); *see also* 42 CFR § 600.320(c)).

Medicaid Eligibility 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).

On the date of your application, that was the 2017 FPL, which is $24,600.00 for a four-person household (82 Federal Register 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).

Household Size

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).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and 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).

Legal Analysis

The only issue under review is whether NYSOH properly cancelled your Essential Plan coverage and began your Medicaid coverage effective December 1, 2017.

Your account confirms you were enrolled in an Essential Plan effective December 1, 2017 based on an annual redetermination of your eligibly by NYSOH as of September 21, 2017. You contacted NYSOH on November 7, 2017 and your application was updated to report your pregnancy for the first time. Following this update, your eligibility was redetermined for a household size of four, including your unborn child, and you were determined eligible for Medicaid, effective December 1, 2017.

The application that was submitted on November 7, 2017 listed an annual household income of $39,206.00, which consisted of (1) $500.00 per week you receive from your employment with [redacted] (2) $5,406.00 you earned from your employment with [redacted] between January 1, 2017 and June 30, 2017, and (3) $7,800.00 your spouse earned from [redacted] between May 1, 2017 and December 1, 2017. This application also reflected that you were pregnant with one child. The eligibility determination relied upon that information.

For Medicaid review purposes, you are in a four-person household. At the time of your application, you lived with your spouse, your older child, and were pregnant with one child.

Medicaid can be provided through NYSOH to pregnant women who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 223% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $24,600.00 for a four-person household. Since $39,206.00 is 159.37% 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.

Pursuant to the above cited regulations, to be eligible for the Essential Plan, applicants must not be otherwise eligible for minimum essential coverage. As discussed above, you were determined eligible for Medicaid as of December 1, 2017. As Medicaid is considered minimum essential coverage, you were no longer eligible to enroll in the Essential Plan as of December 1, 2017.

Therefore, the November 8, 2017 eligibility determination notice is AFFIRMED.

Decision

The November 8, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 2, 2018

How this Decision Affects Your Eligibility

Your Essential Plan coverage was cancelled effective December 1, 2017, and your limited enrollment in that coverage will end.

Your Medicaid coverage began effective December 1, 2017.

You case is returned to NYSOH to assist you in enrolling a plan for which you are eligible.

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 case 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 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 November 8, 2017 eligibility determination notice is AFFIRMED.

Your Essential Plan coverage was cancelled effective December 1, 2017, and your limited enrollment in that coverage will end.

Your Medicaid coverage began effective December 1, 2017.

You case is returned to NYSOH to assist you in enrolling a plan for which you are eligible.

Legal Authority

We are issuing this determination 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.

□□ (Traditional Chinese)

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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.

□□□ (Korean)

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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।

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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.

□□□□□ (Hindi)

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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。

□□□□□□ (Nepali)

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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.

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