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

Notice of Decision

Decision Date: February 05, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024160

[redacted]

[redacted],

On January 22, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 17, 2017 discontinuance notice and November 9, 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 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: February 05, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024160

[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 your enrollment in a Medicaid Managed Care plan ended effective October 31, 2017?
>
> Did NYSOH properly determine that you were eligible for a full cost qualified health plan, effective December 1, 2017.

Procedural History

On November 12, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid effective November 1, 2016.

Also on November 12, 2016, NYSOH issued an enrollment confirmation notice stating that the type of Medicaid coverage you were eligible for did not require or allow you to enroll in a health plan.

On November 18, 2016, you updated your NYSOH account and indicated that you were enrolled in health coverage through your employer which met the minimum value standard.

On November 19, 2016, NYSOH issued a notice of eligibility determination stating that you were conditionally eligible for Medicaid, effective November 1, 2016. The notice directed you to provide proof of third party health insurance by December 3, 2016.

Also on November 19, 2016, NYSOH issued an enrollment confirmation notice stating that the type of Medicaid coverage you were eligible for did not require or allow you to enroll in a health plan.

On September 3, 2017, NYSOH issued a notice that it was time to renew your health insurance. That notice stated that, based on information from federal and state sources, NYSOH could not determine whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by October 15, 2017 or you might lose the financial assistance you were currently receiving.

No updates were made to your account by October 15, 2017.

On October 16, 2017, NYSOH redetermined your eligibility.

On October 17, 2017, NYSOH issued an eligibility determination notice stating that you are not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a qualified health plan at full cost. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame. Your eligibility ended October 31, 2017.

On November 8, 2017, NYSOH received your updated application for health insurance wherein you attested to a household income of $21,645.00. In addition, you updated your application to reflect that you have been enrolled in health coverage through your employer, for the entire year of 2017, at no cost to you. That day, a preliminary eligibility determination was prepared regarding that application, stating that you were eligible for a full cost qualified health plan.

Also on November 8, 2017, you spoke to NYSOH's Account Review Unit and appealed the loss of your Medicaid coverage, effective October 31, 2017 and your full cost qualified health plan determination.

On November 9, 2017, NYSOH issued an eligibility redetermination notice stating that you were eligible for a full cost qualified health plan, effective December 1, 2017. The notice stated you were not eligible for Medicaid because your household income exceeded the allowable income limit. The notice also stated that you were not eligible for the Essential Plan or advance premium tax credits because you are enrolled in employer sponsored health insurance that meets minimum value.

On January 22, 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 determined eligible for Medicaid, effective November 1, 2016.

2) On September 3, 2017, NYSOH issued a renewal notice directing you to renew your health insurance October 15, 2017.

3) No updates were made to your account by October 15, 2017.

4) On October 17, 2017, NYSOH determined that you were ineligible for financial assistance because you had not completed your renewal within the required timeframe, effective October 31, 2017.

5) You testified, and the record reflects, that you receive your notices from NYSOH by regular mail.

6) You testified that you did not receive any notices telling you that you needed to update your application to renew your Medicaid coverage.

7) No notices sent to you at the address listed on your NYSOH account have been returned as undeliverable.

8) The record reflects that on November 8, 2017, NYSOH received your updated application for health insurance wherein you attested to a household income of $21,645.00.

9) On November 9, 2017, NYSOH redetermined you eligible for a full cost qualified health plan because you were enrolled in employer sponsored health insurance that met minimum value.

10) You testified that you are eligible for and currently enrolled in health insurance through your employer which has a $0.00 annual cost to you. You testified that you have had this coverage for the entirety of 2017 and are enrolled in coverage for 2018.

11) You testified that you are appealing the loss of your Medicaid coverage effective October 31, 2017 and your subsequent full cost qualified health plan determination.

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

Applicable Law and Regulations

Medicaid Renewal

In general, NYSOH must review Medicaid eligibility once every twelve months or "whenever it receives information about a change in a beneficiary's circumstances that may affect eligibility" (42 CFR § 435.916(a)(1), (d)). NYSOH must make its "redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency" (42 CFR § 435.916(a)(2)).

NYSOH must provide an individual with the annual redetermination notice, including the projected eligibility for coverage and financial assistance, and must require the qualified individual to report any changes within 30 days (45 CFR § 155.335(c), (e)). Once the 30-day period has lapsed, NYSOH must issue a redetermination as provided by the notice, with consideration given to any updates provided by the individual (45 CFR §155.335(h)).

An individual is eligible for fee-for-service Medicaid effective on the first day of the month if an individual was eligible any time during that month (42 CFR § 435.915(b)).

Medicaid Managed Care (MMC) plan enrollments received on or before the fifteenth day of the month are effective the first day of the following month. Enrollments received after the fifteenth day of the month are effective the first day of the second following month (Medicaid Managed Care Model Contract (Appendix H(6)(b)(ii) & (iii), effective 3/1/2014 – 2/28/2019, N.Y. Soc. Serv. Law §364-j(1)(c); 18 NYCRR § 360-10.3(h)).

Advance Payments of the Premium Tax Credit

An APTC is available to a person who is eligible to enroll in a qualified health plan and

1. expects to have a household income between 138% and 400% of the Federal Poverty Line (FPL),

2. expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and

3. is not otherwise eligible for minimum essential coverage except through the individual market (45 CFR § 155.305(f)).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

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).

Employer-Sponsored Insurance

An employee who may enroll in an employer-sponsored health insurance plan and an individual who may enroll in the plan because of a relationship to the employee are considered eligible for minimum essential coverage if the plan “is affordable and provides minimum value” (26 CFR § 1.36B-2(c)(3)(i)).

An eligible employer-sponsored plan is “affordable” if the portion of the annual premium that the employee or related individual must pay for self-only coverage does not exceed the required contribution. The required contribution percentage is 9.69% of the employee’s household income for 2017 (26 CFR §1.36B-2(c)(3)(v), IRS Rev. Proc. 2016-24).

Medicaid for Adults between the Ages of 19 and 65

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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your Medicaid coverage ended effective October 31, 2017.

You were originally found eligible for Medicaid effective November 1, 2016.

Generally, NYSOH must redetermine a qualified individual's eligibility for Medicaid once every 12 months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency. NYSOH's September 3, 2017 renewal notice stated that there was not enough information to determine whether you were eligible to continue your financial assistance for health insurance, and that you needed to supply additional information by October 15, 2017, or your financial assistance might end.

Because there was no timely response to this notice, your Medicaid coverage ended effective October 31, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified, and your NYSOH account confirms, that you elected to receive notifications by regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

The Appeals Unit finds that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated to ensure your enrollment in your health plan and eligibility for financial assistance would continue. When you failed to update your account, NYSOH properly discontinued your coverage.

Therefore, the October 17, 2017 discontinuance notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined that you were eligible for a full cost qualified health plan, effective December 1, 2017.

In the eligibility determination notice issued on November 9, 2017, NYSOH denied APTC and the Essential Plan to you because you were eligible for or enrolled in health insurance coverage through your employer. The notice also

stated that you were not eligible for Medicaid because your household income exceeded the allowable income limit.

An employee or a related individual to the employee, who is eligible to enroll in an employer-sponsored health insurance plan that is affordable and provides minimum value, is not eligible for APTC or the Essential Plan through NYSOH.

During the hearing, you testified that you are enrolled in employer-sponsored insurance through your employer. You testified that the insurance through this employer is provided to you at no cost. Employer-sponsored health insurance coverage is considered affordable if it costs no more than 9.69% of the household income. NYSOH uses the amount you would pay for self-only coverage through an employer to calculate whether a plan is affordable.

To be eligible for Medicaid, you would have needed to meet the non-financial criteria and have an income no greater than 138% of the FPL for 2017, which is $16,643.00 annually. There is no indication in the record that you would have been ineligible for Medicaid based on non-financial criteria for 2017. You testified, and NYSOH records reflect that your annual income is $21,645.00. As such, NYSOH properly determined that you were not eligible for Medicaid coverage during 2017.

Since you have health insurance coverage through your employer that costs less than 9.69% of your household income and there is no indication in the record that the coverage does not provide minimum value to you, and you do not meet the income requirements for Medicaid, the November 9, 2017 eligibility determination is correct and is AFFIRMED.

Decision

The October 17, 2017 discontinuance notice is AFFIRMED.

The November 9, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 05, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

The end date of your Medicaid coverage is October 31, 2017.

You are not eligible for financial assistance through NYSOH.

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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 17, 2017 discontinuance notice is AFFIRMED.

The November 9, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

The end date of your Medicaid coverage is October 31, 2017.

You are not eligible for financial assistance through NYSOH.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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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।

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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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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.

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