

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

Notice of Decision

Decision Date: February 8, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000024452

[REDACTED]

[REDACTED]

On January 9, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 1, 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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Decision Date: February 8, 2018

NY State of Health Account ID: [REDACTED]
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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 to enroll in the Essential Plan, for a limited time, effective November 1, 2017?

Did NY State of Health properly determine that you were not eligible for Medicaid as of your September 27, 2017 application?

Procedural History

On September 27, 2017, NYSOH received an update to your application for financial assistance with health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you were eligible for the Essential Plan, for a limited time, effective November 1, 2017.

On September 28, 2017, NYSOH issued an enrollment notice confirming your selection of an Essential Plan as of September 27, 2017, with such coverage beginning November 1, 2017.

On October 1, 2017, NYSOH issued an eligibility determination notice based on the information contained in your September 27, 2017 application. The notice stated that you were eligible for the Essential Plan, for a limited time, effective November 1, 2017. The notice requested that you provide income documentation to NYSOH by December 26, 2017 so that your eligibility could be confirmed.

On November 16, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not eligible for Medicaid.

On December 28, 2017, NYSOH received an earnings statement issued to you by your employer, [REDACTED], on November 15, 2017.

On January 9, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: all earnings statements issued to you by your employer during the month of your application, September 2017. The record was to be closed on January 12, 2018, or upon the receipt of the above referenced documents, whichever occurred earlier.

On January 11, 2018, you provided to NYSOH Appeals Unit the above-referenced documents by facsimile.

Accordingly, the record was closed on January 11, 2018.

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 only.
- 3) The application that was submitted on September 27, 2017, which requested financial assistance, listed annual household income of \$17,000.00 consisting solely of income you receive from your employer, [REDACTED]. You testified that this amount was correct.
- 4) You testified, and your NYSOH application reflects, that you will not be taking any deductions on your 2017 tax return.
- 5) You live in [REDACTED], New York.
- 6) On December 28, 2017, you provided an earnings statement confirming that you received \$778.05 from your employer on November 15, 2017.
- 7) On January 11, 2018, you provided two earnings statements reflecting that you received \$1,031.94 on September 6, 2017, and \$999.05 on September 20, 2017.

- 8) You testified that you were seeking to remain in the Medicaid plan you were previously enrolled in to continue seeing your physician since he does not accept the Essential Plan.

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).

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

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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 first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, for a limited time, effective November 1, 2017.

The application that was submitted on September 27, 2017 listed an annual household income of \$17,000.00 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 not dependents on that tax return.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) 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. Since an annual household income of \$17,000.00 is 143.10% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

The second issue under review is whether NYSOH properly determined that you were not eligible 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 \$17,000.00 is 140.96% of the 2017 FPL, NYSOH properly found you to be not eligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

Your NYSOH account reflects that you submitted two earnings statements issued to you on September 6, 2017 and September 20, 2017 that shows during the month of your application, September 2017, you received \$2,030.99.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,387.00 per month. Since the documentation you provided shows that you earned \$2,030.99 in September 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the October 1, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan, for a limited time, and not eligible for Medicaid, it was correct and is AFFIRMED.

Decision

The October 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 8, 2018

How this Decision Affects Your Eligibility

You were eligible for the Essential Plan for a limited time, effective November 1, 2017.

You are not eligible for Medicaid.

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.

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).

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

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Summary

The October 1, 2017 eligibility determination notice is AFFIRMED.

You were eligible for the Essential Plan for a limited time, effective November 1, 2017.

You are not eligible for Medicaid.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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। यदि आपको इसका अर्थ समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपको अपनी भाषा में एक नि:शुल्क व्याख्याता प्रदान कर 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 एक महत्वपूर्ण दस्तावेज हो। यदि तपाईं यसको अर्थ बुझ्नमा सहायता चाहिए, तब 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंको भाषामा नि:शुल्क व्याख्याता प्रदान गर्न 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&etumi ama wo obi a okyerε 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 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.

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