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

Notice of Decision

Decision Date: February 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024547

[redacted]

[redacted]

On February 2, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 16, 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: February 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024547

[redacted]

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 eligible for Medicaid, effective November 1, 2017?

Procedural History

On October 23, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan, effective December 1, 2016.

On October 28, 2016, NYSOH issued an enrollment notice confirming your selection of an Essential Plan as of October 27, 2016, with such coverage beginning effective December 1, 2016.

On September 21, 2017, NYSOH issued a renewal and eligibility determination notice stating that based on information about you obtained from state and federal sources as of September 20, 2017, you had been found to qualify to receive up to $376.58 per month in advance payments of the premium tax credit (APTC), if you selected a silver-level plan, eligible for cost-sharing reductions (CSR), both effective December 1, 2017. You were advised to select a qualified health plan (QHP) between October 16, 2017 and November 15, 2017.

On October 17, 2017, NYSOY issued a disenrollment notice confirming that your Essential Plan coverage would end on November 30, 2017.

On November 3, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On November 4, 2017, NYSOH issued a notice stating that the income information in your application did not match information NYSOH received from state and federal sources. You were requested to provide income documentation to NYSOH by November 18, 2017 so that an appropriate eligibility determination could be issued.

On November 14, 2017, NYSOH received (1) notice of award issued by the Social Security Administration reflecting that you were found eligible to receive $818.00 per month in retirement benefits, beginning April 2017, (2) a copy of your Individual Income Tax Return for 2016, reflecting an adjusted gross income of $33,566.00, and (3) the corresponding Schedule C for your spouse's [redacted] business reflecting a net profit of $27,207.00 (line 29) for 2016.

On November 15, 2017, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On November 16, 2017, NYSOH issued an eligibility determination notice stating that you were found eligible for Medicaid, effective November 1, 2017. This was because your household income of $6,544.00 was at or below the allowable income limit for that program.

On November 17, 2017, NSYOH received an update to your application for financial assistance with health insurance.

On November 18, 2017, NYSOH issued an eligibility determination notice stating that you were found not eligible for Medicaid, effective December 1, 2017.

Also on November 18, 2017, you spoke to NYSOH's Account Review Unit and appealed the November 16, 2017 eligibility determination notice insofar as you were found eligible for Medicaid, and not for an APTC with which to purchase a QHP.

On November 24, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On November 25, 2017, NYSOH issued an eligibility determination notice stating that you were found eligible for an APTC of up to $327.00 per month, effective January 1, 2018.

Also on November 25, 2017, NYSOH issued an enrollment notice confirming your selection of a bronze-level QHP as of November 24, 2017, with such coverage beginning on January 1, 2018.

On November 29, 2017, NYSOH issued an eligibility determination notice stating that you were found eligible for the Essential Plan with a $20.00 monthly premium for a limited time, effective December 1, 2017. The notice further stated that this eligibility determination notice was issued in response to your request for Aid to Continue.

Also on November 29, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your bronze-level QHP would end effective January 1, 2018.

On February 2, 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 support the following findings of fact:

1) You testified that you expect to file your 2017 federal income tax return as married filing jointly, and claim no dependents.

2) According to the November 3, 2017 application, you attested to only receiving Social Security benefits at a monthly rate of $818.00 over eight months. You testified that this income was not an accurate representation of your total expected household income.

3) You further testified that at the time of the November 3, 2017 application, the NYSOH representative who assisted you with your application inadvertently did not include your spouse's income from his [redacted] business.

4) In response to the information contained in your November 3, 2017 application, NYSOH requested that you provide income documentation to confirm your eligibility by November 18, 2017.

5) On November 14, 2017, you provided (1) notice of award issued by the Social Security Administration reflecting that you were found eligible to receive $818.00 per month in retirement benefits, beginning April 2017, (2) a copy of your Individual Income Tax Return for 2016, reflecting an adjusted gross income of $33,566.00, and (3) the corresponding Schedule C for your spouse's [redacted] business reflecting a net profit of $27,207.00 (line 29) for 2016.

6) You testified that you believed that your 2017 income would be similar to that amount referenced in your 2016 tax return, in addition to your anticipated Social Security benefits.

7) You testified that because of the additional income documentation provided to NYSOH, you were found eligible for Medicaid, effective November 1, 2017. You further testified that this was in error, and was due to NYSOH not including your spouse's income.

8) You testified that you were seeking to be found eligible for APTC to purchase a health plan rather than Medicaid.

9) According to the November 17, 2017 application, you attested to an increased expected household income of $41,916.00, which was inclusive of your Social Security benefits and your spouse's anticipated net earnings from his [redacted] business over the months of August, September and October 2017.

10) You live in Ulster County, New York.

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

Applicable Law and Regulations

Medicaid for Adults between the Ages of 19 and 65

Medicaid through NYSOH can be provided 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 federal poverty level (FPL) for the applicable family size (42 CFR §§ 435.119(b), 435.911(b)(1), 435.603(d)(4); NY Social Services Law § 366(1)(b)).

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).

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 $16,249.00 for a two-person household (82 Federal Register 8831).

Most adults determined eligible for Medicaid are guaranteed 12 months of Medicaid coverage even if they lose Medicaid eligibility because of any changes or updates they make to their NYSOH account. For example, even if income increases above the Medicaid limit allowed for the household size, the insured

will remain covered under Medicaid for a 12-month period. This 12-month period is referred to as “continuous coverage” and is set based on the start date of the original Medicaid eligibility determination or the date of a subsequent Medicaid eligibility determination based on modified adjusted gross income (NY Social Services Law § 366(4)(c)).

An individual will be enrolled or remain in their Medicaid plan with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, failing to provide a valid social security number, or having third party health insurance (NY Social Services Law § 366(4)(c)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible for Medicaid effective November 1, 2017.

You are in a two-person household. According to the record, you expect to file your 2017 tax return as married filing jointly and claim no dependents.

Your NYSOH account reflects that because of a redetermination based on the information contained in your account as of September 20, 2017, you were found eligible for APTC of up to $376.58 per month and, if you selected a silver-level plan, eligible for CSR, both effective December 1, 2017. Accordingly, your prior Essential Plan coverage was set to end effective November 30, 2017.

Your NYSOH account further reflects that you updated your account on November 3, 2017. In response to this application update, you were requested to provide additional income documentation by November 18, 2017 to determine your eligibility.

In response to the November 3, 2017 request for documentation, you testified that you provided to NYSOH (1) a notice of award issued by the Social Security Administration reflecting that you were found eligible to receive $818.00 per month in retirement benefits, beginning April 2017, (2) a copy of your Individual Income Tax Return for 2016, reflecting an adjusted gross income of $33,566.00, and (3) the corresponding Schedule C for your spouse’s [redacted] business reflecting a net profit of $27,207.00 (line 29) for 2016.

However, rather than redetermine your eligibility based on your Social Security benefits and your spouse’s projected income for 2017, NYSOH redetermined your eligibility based solely on an annual household income of $6,544.00 ($818.00 x 8 months).

Since the record as developed, and your credible testimony, no longer support that you were eligible for Medicaid, the November 16, 2017 eligibility determination is hereby RESCINDED.

Accordingly, your eligibility as determined in the September 21, 2017 renewal and eligibility determination notice is reinstated. However, since the 2017 plan year had passed, and you did not select a plan a QHP at that time, your proper recourse would be to claim the APTC you did not receive for December 2017 as a credit toward your return when you file your 2017 tax return.

This Decision has no effect on the November 25, 2017 eligibility determination notice finding your eligible for an APTC of up to $327.00 per month, effective January 1, 2018.

Furthermore, your case is RETURNED to NYSOH to, at your option, either: (1) select a QHP for enrollment within 60 days of the hearing date, February 2, 2018, for enrollment through the end of the 2018 plan year, or (2) reinstate your bronze-level QHP plan coverage beginning January 1, 2018, if you remit the necessary premiums to the insurance plan carrier.

Decision

The November 16, 2017 eligibility determination is RESCINDED

Your case is RETURNED to NYSOH to, at your option, either: (1) select a QHP for enrollment within 60 days of the hearing date, February 2, 2018, for enrollment through the end of the 2018 plan year, or (2) reinstate your bronze-level QHP plan coverage beginning January 1, 2018, provided that, you remit the necessary premiums to the insurance plan carrier.

Effective Date of this Decision: February 16, 2018

How this Decision Affects Your Eligibility

You are not eligible for Medicaid.

Your Essential Plan coverage ends on December 31, 2017 or on the day immediately preceding your enrollment in a QHP, which shall be selected no later the 60 days from the hearing date, February 2, 2018.

If you elect to reinstate your QHP coverage beginning January 1, 2017, your APTC of up to $327.00 per month shall be applied to your premium.

If you elect to select a QHP for the remainder of the 2018 plan year, you APTC will be recalculated based on the remaining months of coverage during 2018.

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 16, 2017 eligibility determination is RESCINDED

Your case is RETURNED to NYSOH to, at your option, either: (1) select a QHP for enrollment within 60 days of the hearing date, February 2, 2018, for enrollment through the end of the 2018 plan year, or (2) reinstate your bronze-level QHP plan coverage beginning January 1, 2018, provided that, you remit the necessary premiums to the insurance plan carrier.

You are not eligible for Medicaid.

At your option, your Essential Plan coverage ends on December 31, 2017, or on the day immediately preceding your enrollment in a QHP, which shall be selected no later the 60 days from the hearing date, February 2, 2018.

If you elect to reinstate your QHP coverage beginning January 1, 2017, your APTC of up to $327.00 per month shall be applied to your premium due for each month.

However, if you elect to select a QHP for the remainder of the 2018 plan year, your APTC will be recalculated based on the remaining months of coverage during 2018.

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.

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 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.

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).