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

Notice of Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024755

[redacted]

Dear [redacted]

On February 1, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 23, 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 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 Date: March 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024755

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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 (NYSOH) properly determine that you and your spouse were eligible for the Essential Plan for a limited time, effective January 1, 2018?
>
> Did NYSOH properly determine that you and your spouse were not eligible for Medicaid?

Procedural History

On November 22, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you and your spouse were eligible for the Essential Plan for a limited time, effective January 1, 2018.

Also on November 22, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you and your spouse were not determined eligible for Medicaid, effective December 1, 2017.

On November 23, 2017, NYSOH issued an eligibility determination notice, based on the November 22, 2017 application, stating that you and your spouse were eligible for the Essential Plan for a limited time, effective January 1, 2018. That notice also stated that you were not eligible for Medicaid because your income was over the allowable income limits for that program. You were also directed to

produce income documentation by February 20, 2018, to confirm your and your spouse's eligibility.

On December 4, 2017, an application for health insurance was run on your behalf.

On December 5, 2017, NYSOH issued an eligibility determination notice, stating that you and your spouse were eligible for Medicaid for a limited time, effective December 1, 2017, because you were granted Aid to Continue until a decision is made on your appeal.

Also on December 5, 2017, NYSOH issued a plan enrollment notice confirming that you and your spouse were enrolled in a Medicaid Managed Care plan, effective December 1, 2017.

On February 1, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to February 15, 2018, to allow you to submit supporting documents.

On February 5, 2018, you faxed supporting documents to NYSOH. They were made part of the record as Appellant's Exhibit #1, and the record was closed that day.

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 married filing jointly. You will claim no dependents on that tax return.

2) You are seeking health insurance for you and your spouse; specifically, Medicaid.

3) The application that was submitted on November 22, 2017, listed annual household income of $22,880.00, consisting of income you earn from employment, and a monthly income of $0.00. You testified that the annual household income amount was incorrect.

4) You testified that your annual household income is $0.00. You provided a termination letter from your employer, which states that your last day worked was November 30, 2016. You also provided a letter from Unemployment Insurance, which states that your benefit year starts on December 5, 2016 and ends on December 10, 2017. You testified that you received six months of unemployment benefits and have had no income since.

5) You testified that your spouse has not worked in twelve years.

6) Your application states that you and your spouse will not be taking any deductions on your 2017 tax return.

7) Your application states that you and your spouse live in Bronx County, NY.

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 2017 FPL, which is $16,240.00 for a two-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 https://www.medicaid.gov/basic-health-program/basic-health-program.html).

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).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

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 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 $16,240.00 for a two-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 and your spouse were eligible for the Essential Plan for a limited time, effective January 1, 2018.

The application that was submitted on November 22, 2017, listed an annual household income of $22,880.00 and the eligibility determination relied upon that information.

You and your spouse are in a two-person household for purposes of this analysis. This is because you expect to file your 2017 income taxes as married filing jointly and will claim no 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 that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since an annual household income of $22,880.00 is 140.8982% of the 2017 FPL, NYSOH properly found you to be eligible for the Essential Plan based on the information in the November 22, 2017 application.

The second issue under review is whether NYSOH properly determined that you and your spouse 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 $16,240.00 for a two-person household. Since $22,880.00 is 140.89% of the 2017 FPL, NYSOH properly found you and your spouse to be not eligible for Medicaid on an expected annual income basis, using the information provided in your application.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits can be based on current monthly household income and family size. However, your November 22, 2017 application states that you elected to have your eligibility determined using a projected yearly income, so NYSOH did not determine your eligibility based on the current monthly income listed in your application.

Since the November 23, 2017 eligibility determination properly stated that, based on the information in the November 22, 2017 application, you and your spouse were eligible for the Essential Plan for a limited time and not eligible for Medicaid, it is correct and is AFFIRMED.

However, you credibly testified that the income information in the November 22, 2017 application is not correct. You testified that your annual expected household income in 2018 is $0.00. Following the hearing, you provided a termination letter from your prior employer, which states that your last day worked was November 30, 2016. You also provided a letter from Unemployment Insurance, which states that your benefit year starts on December 5, 2016 and ends on December 10, 2017. You credibly testified that you received six months of unemployment benefits and have had no income since. You testified that your spouse has not worked in twelve years.

THEREFORE, based on the foregoing and most current information regarding your household income, your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance based on an annual expected household income of $0.00 and a two-person household, for a couple living in Bronx County, NY.

Decision

The November 23, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance based on an annual expected household income of $0.00 and a two-person household, for a couple living in Bronx County, NY.

Effective Date of this Decision: March 14, 2018

How this Decision Affects Your Eligibility

You and your spouse were properly determined eligible for the Essential Plan.

You and your spouse were properly determined not eligible for Medicaid.

This is not a final determination of your and your spouse's eligibility going forward.

Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility based on the record as developed at the hearing and post-hearing. NYSOH will notify you of its redetermination.

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
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The November 23, 2017 eligibility determination notice is AFFIRMED.

You and your spouse were properly determined eligible for the Essential Plan.

You and your spouse were properly determined not eligible for Medicaid.

This is not a final determination of your and your spouse's eligibility going forward.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance based on an annual expected household income of $0.00 and a two-person household, for a couple living in Bronx County, NY.

Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility based on the record as developed at the hearing and post-hearing. NYSOH will notify you of its redetermination.

Legal Authority

We are sending you this notice 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).