



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

Notice of Decision

Decision Date: February 15, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025291

[REDACTED]

[REDACTED]

On February 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 5, 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.



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

Decision

Decision Date: February 15, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025291

[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 you and your spouse were eligible to enroll in the Essential Plan effective January 1, 2018?

Did NYSOH properly determine that you and your spouse were not eligible for Medicaid, as of your December 4, 2017 application?

Procedural History

On November 21, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On November 22, 2017, NYSOH issued an eligibility determination based on the information contained within the November 21, 2017 application, stating that you and your spouse were found conditionally eligible for Medicaid, effective December 1, 2017. You were requested to provide income documentation to confirm your eligibility, but the notice did not specify the due date by which the income documents were required to be provided to NYSOH.

Also on November 22, 2017, NYSOH issued an enrollment notice confirming your selection of a Medicaid Managed Care (MMC) plan for you and your spouse on November 21, 2017, with such coverage beginning January 1, 2018.

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).

On December 1, 2017, NYSOH received four earnings statements issued to your spouse by his employer, [REDACTED], between October 24, 2017 and November 14, 2017.

On December 4, 2017, NYSOH redetermined your household's eligibility for financial assistance with health insurance. In response to this redetermination, NYSOH prepared a preliminary eligibility determination stating that you and your spouse were each found eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective January 1, 2018.

Also on December 4, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you and your spouse were not eligible for Medicaid. You and your spouse were each found eligible for "Aid to Continue" during the pendency of the appeal, so you were reenrolled in the your MMC plan for a limited time.

On December 5, 2017, NYSOH issued an eligibility determination notice, stating that you and your spouse were each found eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective January 1, 2018. It further stated that you and your spouse were longer eligible to remain enrolled in Medicaid since your household income was over the allowable income limit for that program.

On February 8, 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: the final two earnings statements your spouse received during the month of November 2017. The record was to be closed on February 12, 2017, or upon the receipt of the above referenced documents, whichever occurred earlier.

On February 10, 2018, you provided to NYSOH Appeals Unit through facsimile the final two earnings statements your spouse received during the month of November 2017.

Accordingly, the record was closed on February 10, 2018.

Findings of Fact

A review of the record support 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 insurance for you and your spouse.

- 3) Your household's eligibility was redetermined based on the information contained in your NYSOH account as of December 4, 2017, in which you requested financial assistance for your household. Your household's eligibility was redetermined based on an annual household income of \$25,883.00, which was derived from your spouse's average weekly salary of \$497.75, as reflected in the earnings statements provided to NYSOH on December 1, 2017. You testified that this amount was correct, though further stated that his income fluctuates based upon the work available at that time.
- 4) You testified that you were not currently employed, and rely upon your spouse's income for support.
- 5) On December 1, 2017, you provided NYSOH four earnings statements reflecting that your spouse received (1) \$132.00 on October 24, 2017, (2) \$814.00 on October 31, 2017, (3) \$649.00 on November 7, 2017, and (4) \$396.00 on November 14, 2017.
- 6) Your NYSOH application reflects that you will not be taking any deductions on your 2017 tax return.
- 7) You live in Kings County, New York.
- 8) On February 10, 2018, you provided to NYSOH Appeals Unit two additional earnings statements issued to your spouse reflecting that he received (1) \$825.00 on November 21, 2017 and (2) \$385.00 on November 28, 2017.
- 9) You testified that you were seeking for you and your spouse to be found eligible for Medicaid, rather than the Essential Plan, since you are unable to afford the Essential Plan premiums and co-pays based on your overall income.

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

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).

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 (82 Federal Register 8831).

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, effective January 1, 2018.

Your household's eligibility was redetermined based on the information contained in your NYSOH account as of December 4, 2017, which contained four earnings statements reflecting that your spouse received (1) \$132.00 on October 24, 2017, (2) \$814.00 on October 31, 2017, (3) \$649.00 on November 7, 2017, and (4) \$396.00 on November 14, 2017. Accordingly, your eligibility was based on your average weekly salary of \$497.75 over 52 weeks. Your annual household income was redetermined to be \$25,883.00 (\$97.75 x 52 weeks). The eligibility determination relied upon that information.

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).

You and your spouse are in a two-person household. 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 (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 \$16,240.00 for a two-person household. Since an annual household income of \$25,883.00 is 159.38% of the 2017 FPL, NYSOH properly found you to be eligible for the Essential Plan.

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 \$25,883.00 is 159.38% of the 2017 FPL, NYSOH properly found you and your spouse were 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.

On December 1, 2017 and February 10, 2017, you provided a combined four earnings statements reflecting that your spouse's income during the month of your original application, November 2017, was \$2,255.00.

To be eligible for Medicaid, you and your spouse would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,868.00 per month. Since the documentation you provided shows that your spouse earned \$2,255.00 in November 2017, you and your spouse do not qualify for Medicaid based on monthly income as of the date of your application.

Since the December 5, 2017 eligibility determination properly stated that, based on the information you provided, you and your spouse were eligible for the Essential Plan, and were not eligible for Medicaid, it was correct and is **AFFIRMED**.

Decision

The December 5, 2017 eligibility determination is **AFFIRMED**.

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).

Effective Date of this Decision: February 15, 2018

How this Decision Affects Your Eligibility

You and your spouse were eligible for the Essential Plan with a \$20.00 monthly premium, effective January 1, 2018.

You and your spouse were not eligible for Medicaid, and your limited enrollment in that coverage will end.

Your 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:

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).

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 December 5, 2017 eligibility determination is AFFIRMED.

You and your spouse were eligible for the Essential Plan with a \$20.00 monthly premium, effective January 1, 2018.

You and your spouse were not eligible for Medicaid, and your limited enrollment in that coverage will end.

Your 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.

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).

A Copy of this Decision Has Been Provided To:



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، يرجى الاتصال بالرقم 1-855-355-5777. يمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerε kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

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 איך 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).