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

# Notice of Decision

Decision Date: April 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025405

[redacted]

Dear [redacted]

On February 8, 2018 you appeared by telephone at a hearing on your appeal of NY State of Health's September 21, 2017 renewal 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

# Decision

Decision Date: April 2, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025405

[redacted]

## Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Was your appeal of NY State of Health's September 21, 2017 renewal notice timely?
>
> Did NY State of Health properly determine that you were eligible to enroll in the Essential Plan effective December 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid as of December 1, 2017?

## Procedural History

On December 13, 2016, NY State of Health (NYSOH) received your updated application for financial assistance.

On December 14, 2016, NYSOH issued an eligibility determination based on the December 13, 2016 application, and stated that you were eligible for Medicaid, effective December 1, 2016.

Also on December 14, 2016, NYSOH issued a notice of enrollment that stated that you were enrolled in a Medicaid managed Care plan starting January 1, 2017.

On September 21, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that you

were eligible to enroll in the Essential Plan with a $20.00 per month premium, effective December 1, 2017, because federal and state data sources showed that your income was between $17,820.00 and $23,760.00.

On October 17, 2017, NYSOH issued a notice that your coverage under your Medicaid Managed Care plan would end on November 30, 2017.

Also on October 17, 2017, NYSOH issued a notice of enrollment confirmation, stating that you would be enrolled in an Essential Plan with a plan enrollment start date of December 1, 2017.

On December 6, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the September 21, 2017 renewal notice insofar as you were not eligible for Medicaid.

On January 30, 2018, NYSOH received your updated application for health insurance.

On January 31, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 per month premium, effective March 1, 2018. This notice stated that you were not eligible for Medicaid because your income was above 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 left open up until February 22, 2018 to allow you time to submit proof of your monthly income for September 2017. On February 21, 2018, you uploaded to your NYSOH account a pay schedule was uploaded to your NYSOH account titled [redacted]," that listed a number of check dates and amounts that dated from December 1, 2017, through February 2, 2018. This document was incorporated into the record as Appellant's Exhibit 1. No further documentation was received by the close of business day on February 22, 2018 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 single. You will claim no dependents on that tax return.

2) You are seeking to be found eligible for Medicaid.

3) The renewal notice and eligibility determination issued on September 21, 2017, which found you eligible for the Essential Plan, stated that federal and state sources indicated that your income fell between $17,820.00 and $23,760.00.

4) You testified that your annual income was $20,000.00.

5) On January 30, 2018, you updated your NYSOH account to indicate that your annual household income was $20,000.00.

6) You testified that you were unsure what your monthly income was for September 2017.

7) You testified that you will not be taking any deductions on your 2017 tax return.

8) At the close of the hearing, you were given an opportunity to provide documentation of your September 2017 income by February 22, 2018.

9) The pay schedule uploaded on February 21, 2018, shows that on December 1, 2017 you received a gross pay amount of $639.23, on December 8, 2017 you received a gross pay amount of $567.88, on December 15, 2017 you received a gross pay amount of $572.00, on December 22, 2017, you received a gross pay amount of $396.00, and on December 29, 2017 you received a gross pay amount of $1,005.13.

10) Your application states that you live in [redacted].

11) You testified that you did not receive the September 21, 2017 renewal notice informing you that you would be eligible for the Essential Plan, and not Medicaid, effective December 1, 2017.

12) You testified that you were unaware that you were no longer eligible for Medicaid until you went to [redacted] appointment in December 2017. You further testified that you contacted NYSOH to dispute your Essential Plan eligibility shortly thereafter,

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

## Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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 Fed. Reg. 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).

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 $12,060.00.00 for a 1-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 is whether your appeal of NYSOH's September 21, 2017 renewal notice timely.

On September 21, 2017, NYSOH issued a renewal notice stating that you qualified for health care coverage under the Essential Plan, with a monthly premium of $20.00, effective December 1, 2017.

The record reflects that you first contacted NYSOH to dispute the eligibility listed in the September 21, 2017 renewal notice was on December 7, 2017.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your eligibility for the Essential Plan and ineligibility for Medicaid as of December 1, 2017, an appeal should have been filed by November 20, 2017. The record reflects that you filed your appeal on December 7, 2017, which is beyond the 60-day deadline.

Although your appeal of the September 21, 2017 renewal notice was untimely on its face, you credibly testified that you did not receive the notice informing you that you were eligible for the Essential Plan. Furthermore, you testified that you were unaware that you were no longer eligible for Medicaid until you went to [redacted] appointment in December 2017. You further testified that you contacted NYSOH to dispute your Essential Plan eligibility shortly thereafter.

Accordingly, your failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal, and your appeal will therefore be addressed.

The second issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective December 1, 2017.

The renewal notice dated September 21, 2017, noted that federal and state data sources showed that you had an income between $17,820.00 and $23,760.00, and therefore found you eligible for the Essential Plan, with a monthly premium of $20.00. During the hearing, you testified you're your annual expected income is $20,000.00

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

The Essential Plan for $20.00 per month is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is between 150% and 200% of the FPL for the applicable family size. On the date of your eligibility determination, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $20,000.00 is 168.35% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

The third issue is whether NYSOH properly determined that you were not eligible for Medicaid as of December 1, 2017.

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 the September 21, 2017 renewal notice as well as the effective date of the eligibility listed in that renewal notice, the relevant FPL was $12,060.00 for a one-person household. The September 21, 2017 renewal notice

and eligibility determination stated that federal and state sources indicated that your income was between $17,820 and $23,760. You credibly testified that you make $20,000.00. annually. Since $20,000.00 is 165.84% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, based upon information obtained from federal and state sources.

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

You testified that you were unsure what your specific income was during the month of September 2017, the month in which the notice under review was issued, and indicated you would submit paystubs that would provide proof of your income during that month. However, the pay schedule you submitted did not include paystubs for September 2017. Therefore, an analysis of your eligibility for the month of September cannot be done.

However, the eligibility in the notice under review is for eligibility effective as of December 1, 2017. The pay schedule uploaded on February 21, 2018, shows that in December 2017 you received a gross pay amount of $1,005.13.

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 $3,180.24 in December 2017 you do not qualify for Medicaid on the basis of monthly income as of the effective date of the September 21, 2017 renewal notice.

Since the September 21, 2017 eligibility determination properly stated that you were eligible for the Essential Plan based on the information obtained by federal and state sources, it was correct and is AFFIRMED.

## Decision

The September 21, 2017 renewal notice is AFFIRMED.

## **Effective Date of this Decision:** April 2, 2018

## How this Decision Affects Your Eligibility

NYSOH properly determined that you were eligible for the Essential Plan.

You were not eligible for Medicaid at the time of the September 21, 2017 renewal notice.

## 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 September 21, 2017 renewal notice is AFFIRMED.

NYSOH properly determined that you were eligible for the Essential Plan.

You were not eligible for Medicaid at the time of the September 21, 2017 renewal notice.

## 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.

**□□ (Traditional Chinese)**

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**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.

**□□□ (Korean)**

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**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.

**□□□□□ (Hindi)**

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**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。

**□□□□□□ (Nepali)**

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**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.

**(Urdu)** اردو

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.

**(Yiddish) אידיש**

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).