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

Notice of Decision

Decision Date: April 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027019

[redacted]

[redacted],

On March 27, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 9, 2018 eligibility determination notice and January 10, 2018 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: April 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027019

[redacted]

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 no longer eligible for health insurance through NY State of Health, effective January 9, 2018?
>
> Did NY State of Health properly determine that you were eligible for the Essential Plan, effective February 1, 2018?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On July 5, 2017, you updated your application for financial assistance with health insurance. Specifically, you indicated that you were pregnant.

On July 6, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid, effective July 1, 2017.

On December 27, 2017, NYSOH redetermined your eligibility for financial assistance, based on information that you had given birth.

On December 28, 2017, NYSOH issued a notice of eligibility determination stating that you were no longer eligible for Medicaid, but that your Medicaid coverage would continue until June 30, 2018, effective December 1, 2017.

On January 8, 2018, you updated your application for financial assistance with a certified application counselor and indicated that you did not need health insurance.

On January 9, 2018, NYSOH issued a discontinuance notice stating that you were no longer eligible for health insurance through NYSOH. This was because you longer wanted to receive coverage.

Also on January 9, 2018, you updated your application for financial assistance with health insurance.

On January 10, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan for a limited time, effective February 1, 2018. That notice also stated that you were not eligible for Medicaid because your annual household income was over the allowable income limit for that program. This notice also directed you to submit proof of your household income by April 9, 2018 in order to confirm your eligibility for financial assistance.

Also on January 10, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not found eligible for Medicaid.

On January 26, 2018, NYSOH issued a notice stating that you were eligible for Medicaid for a limited time, effective January 1, 2018. This was because you had been granted Aid to Continue pending the outcome of your appeal.

On March 27, 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 until April 10, 2018, to allow you time to submit supporting documents.

On April 10, 2018, NYSOH received your supporting documents via upload, consisting of five of your paystubs and three of your disability checks. The documents were incorporated into the record as Appellant's Exhibit #1 and the record was closed.

Findings of Fact

A review of the record supports the following findings of fact:

1) You testified that you are seeking to be reinstated into your Medicaid.

2) Your NYSOH account reflects that on July 5, 2017, you reported to NYSOH that you were pregnant. As a result, you were found eligible for Medicaid, effective July 1, 2017.

3) Your NYSOH account reflects that your youngest child was born on [redacted] and that this was reported to NYSOH on December 27, 2017.

4) You testified that there was an issue with your oldest two children's coverage and that you contacted a certified application counselor on [redacted] to help you get your children back on their Child Health Plus plan.

5) On January 8, 2018, a certified application counselor updated your application for financial assistance with health insurance and indicated that you did not need health insurance.

6) You testified that you told the certified application counselor that you did not need to apply for health insurance for yourself.

7) You testified that you learned that you had been disenrolled from your coverage when you received the January 9, 2018 discontinuance notice.

8) Your NYSOH account reflects that on January 9, 2018, you contacted NYSOH and updated your application to indicate that you were applying for health insurance.

9) You testified that you expect to file your tax return for 2018 with a tax filing status of single. You will claim your three children as dependents on that tax return.

10) The application that was submitted on January 9, 2018 listed annual household income of $42,996.30, consisting of $48,000.00 you earn from your employment less $1,872.00 in student loan interest deductions and $3,131.70 in IRA contributions. You testified that you are not sure if this is correct because you were out of work related to your [redacted]

11) You testified that as of the hearing, you intended to return to work on [redacted] and would earn $1,901.60 biweekly.

12) You testified that began receiving disability payments in January 2018 and paid family leave benefits on February 12, 2108. You explained that the disability payments ended when you started receiving paid family leave benefits.

13) You testified that you anticipate claiming approximately $1,193.00 in student loan interest deductions and $3,131.70 in IRA contributions for 2018.

14) Your application states, and you confirmed, that you live in Saratoga County.

15) You uploaded five of your paystubs showing short term disability payments and parental leave payments from your employer; the first is for pay date January 5, 2018 for a gross pay amount of $1,860.34; the second is for pay date January 19, 2018 for a gross pay amount of $1,141.97; the third is for pay date February 2, 2018 for a gross pay amount of $1,141.97; the fourth is for pay date February 16, 2018 for a gross pay amount of $1,230.43; and the fifth is for pay date February 24, 2018 for a gross pay amount of $38.46 and a gross year to date amount of $5,413.17.

16) You uploaded four paystubs showing short term disability payments from your employer's disability carrier; the first is for pay date February 5, 2018 for a gross pay amount of $170.00; the second is for pay date March 1, 2018 for a gross pay amount of $1,052.30; the third is for pay date March 15, 2018 for a gross pay amount of $1,052.30; the fourth is for pay date March 29, 2018 for a gross pay amount of $1,052.30.

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

Applicable Law and Regulations

Medicaid for Pregnant Women

Medicaid can be provided through the Marketplace 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)), N.Y. Soc. Serv. Law § 366(1)(b)).

In New York, a pregnant woman is eligible for Medicaid at a household income of 223% of the federal poverty level (FPL) for the applicable family size (42 CFR §435.116 (c)(2); NY Department of Social Services Administrative Directive 13ADM-03).

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists

of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

For purposes of Medicaid eligibility, the family size of a pregnant woman includes the pregnant woman and the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055-MM3, as approved by the US Department of Health and Human Services, March 19, 2014).

Generally, Medicaid coverage begins on the first day of the month in which the applicant was found eligible (42 CFR § 435.915(b)).

Once a pregnant woman is determined eligible for Medicaid, her coverage will continue through the end of the month in which the sixtieth day following the end of the pregnancy occurs, without regard to any change in the income of the family that includes the pregnant woman, even if such change otherwise would have rendered her ineligible for Medicaid.

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 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 $24,600.00 for a four-person household (82 Fed. Reg. 8831).

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/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 $24,600.00 for a four-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 NYSOH properly determined that you were no longer eligible for health insurance through NYSOH, effective January 9, 2018.

Generally, once a pregnant woman is found eligible for Medicaid, they remain eligible for Medicaid through the end of the month in which the sixtieth day following the end of the pregnancy occurs whether or not their household income increases.

You testified that you contacted your certified application counselor on [redacted] to update your application as there was an issue with your older two children's coverage. You further credibly testified that you advised your certified application counselor that you did not need to apply for coverage. As a result, your application counselor updated your application to reflect that you were not seeking health insurance through NYSOH.

As the credible evidence of record reflects that your certified application counselor updated your application to reflect that you were not seeking health insurance through NYSOH based on statements from yourself, this update was

not in error, and NYSOH properly determined that you were no longer eligible for health insurance through NYSOH, effective January 9, 2018.

Therefore, the January 10, 2018 discontinuance notice is AFFIRMED.

The second issue under review is whether NYSOH properly determined you were eligible for the Essential Plan, effective February 1, 2018.

The application that was submitted on January 10, 2018 listed an annual household income of $42,996.30 and the eligibility determination relied upon that information.

You expect to file your 2018 income tax return as single and will claim three dependents on that tax return. Therefore, you are in a four-person household.

The Essential Plan is generally 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 $24,600.00 for a four-person household. Since an annual household income of $42,993.30 is 174.77% of the 2017 FPL, NYSOH correctly found you to be eligible for the Essential Plan.

The third issue is whether NYSOH properly determined that you were ineligible 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 $24,600.00 for a four-person household. Since $42,993.30 is 174.77% of the 2017 FPL, NYSOH properly found you to be ineligible 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.

You submitted paystubs that show in January 2018 you received $3,272.31.

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 $2,829.00 per month. Since the documentation you provided shows that you earned $3,272.31 in January 2018, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the January 10, 2018 eligibility determination notice properly stated that, based on the information you provided, you were eligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

During the hearing, you testified to, and provided documentation of, different income than what is listed in your application.

Based on your testimony as well as the documentation you submitted, your annual expected income is currently $40,545.77, consisting of $36,130.40 in wages from April 9, 2018 to December 31, 2018, payments from your employer from January 1, 2018 through March 2, 2018 of $5,413.17, payments from your employer's disability carrier of $3,326.90, less student loan interest deductions of $1,193.00 and IRA contributions of $3,131.70.

Therefore, your case is RETUNRED to NYSOH to redetermine your eligibility for financial assistance based on a household of four residing in Saratoga County with an annual expected income of $40,545.77.

Decision

The January 9, 2018 discontinuance notice is AFFIRMED.

The January 10, 2018 eligibility determination notice is AFFIRMED.

Your case is RETUNRED to NYSOH to redetermine your eligibility for financial assistance based on a household of four residing in Saratoga County with an annual expected income of $40,545.77.

Effective Date of this Decision: April 16, 2018

How this Decision Affects Your Eligibility

NYSOH properly found that you were no longer eligible for health insurance through NYSOH.

This is not a final determination of your eligibility for financial assistance.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based on information you provided during your hearing.

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):

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 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 January 9, 2018 discontinuance notice is AFFIRMED.

NYSOH properly found that you were no longer eligible for health insurance through NYSOH.

The January 10, 2018 eligibility determination notice is AFFIRMED.

Your case is RETUNRED to NYSOH to redetermine your eligibility for financial assistance based on a household of four residing in Saratoga County with an annual expected income of $40,545.77.

This is not a final determination of your eligibility for financial assistance.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based on information you provided during your hearing.

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).