



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

Notice of Decision

Decision Date: September 13, 2016

NY State of Health Number: [REDACTED]
Appeal Identification Number: AP000000007632



Dear [REDACTED],

On August 15, 2016, you appeared by telephone at a hearing on your appeal of NY State of Health's February 13, 2016 eligibility determination.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 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).

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Issues

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

Did New York State of Health properly determine that you were eligible to enroll in the Essential Plan as of February 13, 2016?

Did New York State of Health properly determine that you were not eligible for Medicaid as of February 13, 2016?

Procedural History

On February 12, 2016, you submitted a financial assistance application through New York State of Health (NYSOH).

On February 13, 2016, NYSOH issued an eligibility determination notice that based on your February 12, 2016 application, you were eligible to enroll in the Essential Plan, effective as of March 1, 2016.

Also on February 13, 2016, NYSOH issued an enrollment notice confirming that as of February 12, 2016 you were enrolled in Essential Plan 2 Plus Vision and Dental (UnitedHealthcare Community Plan) with a plan enrollment start date of March 1, 2016.

On March 3, 2016, you spoke to NYSOH Account Review Unit and requested an appeal insofar as the amount of financial assistance you were determined eligible to receive.

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On August 15, 2016, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open until August 16, 2016 to allow to submit additional documentation. You were directed to submit the contracts between you and your employers for the 2016 Spring semester.

On August 16, 2016, you uploaded three separate documents to your NYSOH account. The documentation included:

- (a) A letter, dated January 27, 2016, from the Human Resources Director at [REDACTED] ([REDACTED]). This document has been incorporated into the record as "Appellant Exhibit A."
- (b) A letter, dated February 4, 2016, from the [REDACTED] ([REDACTED]). This document has been incorporated into the record as "Appellant Exhibit B."
- (c) An Adjunct Payment Form, dated January 7, 2016, from [REDACTED] ([REDACTED]). This document has been incorporated into the record as "Appellant Exhibit C."

Findings of Fact

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

1. You testified that you are applying for health insurance through NYSOH for yourself.
2. You testified that you plan on filing a 2016 federal income tax return with the tax status of single and will not be claiming any dependents on that tax return.
3. According to your February 12, 2016 NYSOH application, your 2016 expected annual household income is \$16,484.56. Your application lists the following sources of income:
 - (a) \$3,873.76 from [REDACTED] for the period of January 19, 2016 through May 5, 2016;
 - (b) \$7,780.80 from [REDACTED] for the period of January 29, 2016 through May 28, 2016;
 - (c) \$4,830.00 from [REDACTED] for the period of January 12, 2016 through May 20, 2016.
4. According to your February 12, 2016 NYSOH application, you attested that your average monthly income is the same as your current month's income.
5. You testified that you are an [REDACTED] who is employed on a contract basis every school semester.

6. You testified that you have tentative agreements of employment with [REDACTED] and [REDACTED] for the 2016 Fall Semester.
7. You testified that you did not receive any income for the months of June and July 2016, and will not receive any income for the months of August and September 2016.
8. The record was left open until August 16, 2016, to allow you the opportunity to submit your employment contracts for the 2016 spring semester in order to demonstrate your gap in employment.
9. You testified that you have been unable to find a physician who accepts the Essential and want to be found eligible for Medicaid.
10. You were employed as an [REDACTED] at [REDACTED] from January 19, 2016 through May 5, 2016, and was issued \$3,300.00 from February 12, 2016, through May 6, 2016. You also were employed as a [REDACTED] at [REDACTED] and was issued \$573.75 on either May 20, 2016 or June 3, 2016 (Appellant Exhibit A).
11. You were employed as an [REDACTED] at [REDACTED] from January 29, 2016, through May 28, 2016 and was issued \$7,780.80 (Appellant Exhibit B).
12. You were employed at [REDACTED] from January 2016 through May 2016 for the contract amount of \$4,830.00. You were issued four equal payments of \$1,207.50 from February 2016 through May 2016 (Appellant Exhibit C).

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

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§ 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 2015 FPL, which is \$11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

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).

Medicaid:

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 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 2016 FPL, which is \$11,880.00 for a one-person household (81 Fed. Reg. 4036).

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 determining current monthly or projected annual household income and family size, NYSOH may adopt a reasonable method to include a prorated portion of predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income (42 CFR § 435.603(h)(3); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan as of February 13, 2016.

You expect to file your 2016 federal tax return with the tax status single and not claim any dependents on that return. Therefore, you are in a one-person household.

In the application that was submitted on February 12, 2016 you attested to an annual household income of \$16,484.56 and the eligibility determination issued on February 13, 2016 relied on that information.

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 \$11,770.00 for a one-person household. Since \$16,484.56 is 140.06% of the 2015 FPL, NYSOH properly found you to be eligible to enroll in the Essential Plan.

The second issue is whether NYSOH properly determined that you were not eligible for Medicaid as of February 13, 2016.

Medicaid can be provided through the Marketplace to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size.

On the date of your application, the relevant FPL was \$11,880.00 for a one-person household. Since \$16,485.56 is 138.76% of the 2016 FPL, NYSOH properly found you 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 is based on current monthly household income and family size. 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 \$1,367.00 per month.

The record reflects that you indicated on your February 12, 2016 application that your average monthly income is the same as your currently monthly income. Since you attested to an annual income of \$16,485.56, your monthly income was $(\$16,485.56/12)$ \$1,373.80. Therefore, your income exceeded the monthly income threshold.

Therefore, NYSOH properly found you eligible to enroll in the Essential Plan and not eligible for Medicaid.

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However, the credible record supports that your income is not consistent through the year. You are an [REDACTED] who is employed on a contract basis every school semester. The record reflects that you were employed at [REDACTED] [REDACTED] and [REDACTED] [REDACTED] from January 2016 through May 2016. Furthermore, you have tentative agreements of employment with [REDACTED] [REDACTED] and [REDACTED] [REDACTED] for the 2016 Fall Semester, which you do not anticipate to receive any income from until October 2016.

There is sufficient evidence in the record to demonstrate that you were not issued any income for the month of July 2016 and will not receive any income for the month of August 2016.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household with an expected August 2016 monthly household income of \$0.00.

Decision

The February 13, 2016 eligibility determination is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household with an expected August 2016 monthly household income of \$0.00.

Effective Date of this Decision: September 13, 2016

How this Decision Affects Your Eligibility

You remain eligible to enroll in the Essential Plan.

You remain not eligible for Medicaid.

Your case has been returned to NYSOH to recalculate your eligibility for financial assistance based on a monthly income of \$0.00 for August 2016.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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

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must be done within four months after the date 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 U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c))

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

Summary

The February 13, 2016 eligibility determination is AFFIRMED.

You remain eligible to enroll in the Essential Plan.

You remain not eligible for Medicaid.

Your case has been returned to NYSOH to recalculate your eligibility for financial assistance based on a monthly income of \$0.00 for August 2016.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

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A Copy of this Decision Has Been Provided To:

