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

# Notice of Decision

Decision Date: April 04, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014376

[redacted]

Dear [redacted],

On March 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 13, 2016 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

Decision Date: April 04, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014376

[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 eligible for the Essential Plan 1, effective January 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid effective January 1, 2017?

## Procedural History

On December 12, 2016, you submitted an application for financial assistance.

On December 13, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan effective January 1, 2017 with a $20.00 per month premium. The notice stated the household income listed in your application was $21,673.20. You were not eligible for Medicaid because your income was over the allowable income limit for that program.

On December 15, 2016, an enrollment confirmation notice was issued confirming your enrollment in the Essential Plan 1, Vision and Dental with a premium responsibility of $47.49, effective January 1, 2017.

On December 28, 2016, you spoke to NYSOH's Account Review Unit and appealed the fact that your eligibility required a premium payment and that you were no longer eligible for medical transportation through Medicaid.

On March 20, 2017, 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 April 3, 2017, to allow you to submit supporting documents showing your gross monthly wages for December, 2016.

On March 29, 2017, NYSOH received your supporting documentation in the form of copies of your paystubs and were incorporated into the record as (Appellant's Exhibit 1).

## 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 insurance for yourself.

3) The application that was submitted on December 12, 2016 listed annual household income of $21,673.20, consisting of income you earn from your employment of approximately $9.45 an hour for 18 hours a week, and $1,069.00 you receive every month from Social Security Benefits.

4) You testified you received checks from your employer on December 6, 13, 20, and 27, 2016 in the gross amount of $189.00, $149.31, $198.45, $271.69 respectively. You provided supporting documentation showing these amounts (See Appellant's Exhibit 1).

5) Your supporting documentation shows your gross wages for 2016 were $4,957.10 (See Appellant's Exhibit 1, pg. 4).

6) You testified that recently due to illness your hours have been significantly reduced and that so far in 2017 you have only worked one week.

7) You testified you would like to have medical transportation available again to you, you believed you had this benefit when you were eligible for Medicaid.

8) Your application states that you will not be taking any deductions on your 2016 tax return.

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

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 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 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 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 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).

## Legal Analysis

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

Your application submitted on December 12, 2016 stated you expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return. It also listed an annual household income of $21,673.20, consisting of income you earn from your employment and $1,069.00 you receive every month from Social Security Benefits. You testified that this was true, but that your hours would be significantly less for 2017 due to illness.

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 Federal Poverty Level (FPL) for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household.

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. Since an annual household income of $21,673.20 is 182.43% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan based upon the information in your account and the December 13, 2016 eligibility determination notice was correct and is AFFIRMED.

The second issue is whether NYSOH properly determined that you were ineligible for Medicaid effective January 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 your application, the relevant FPL was $11,880.00 for a one-person household. Since $21,673.20 is 182.43% of the 2016 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 applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted checks from your employer dated December 6, 13, 20, and 27, 2016 in the gross amount of $189.00, $149.31, $198.45, $271.69 respectively. You provided supporting documentation showing these amounts (See Appellant's Exhibit 1). Adding this together you received a total $808.45 from employment in the month of December, 2016. You also received $1,069.00 from Social Security Benefits. Therefore, for the month of December, 2016 you received a gross amount of $1,877.45.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have a monthly income no greater than 138% of the FPL, which is $1,367.00 per month. Since the documentation you provided shows that you earned $1,877.45 in December you do not qualify for Medicaid based on monthly income as of the date of your application.

Your supporting documentation shows your gross wages for 2016 were $4,957.10 (See Appellant's Exhibit 1, pg. 4). Since you are receiving twelve months of Social Security Benefits in the amount of $12,828.00 or $1,069.00 per month your annual household income for 2016 was $17,785.00.

Since the December 13, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan 1 and ineligible for Medicaid based on the information you provided, it is correct and is AFFIRMED.

During the hearing, you testified that recently due to illness your hours have been significantly reduced and that so far in 2017 you have only worked one week. If there has been a change in your household income, please update your NYSOH account so that your eligibility can be redetermined accordingly.

## Decision

The December 13, 2016 eligibility determination notice is AFFIRMED.

## **Effective Date of this Decision:** April 04, 2017

## How this Decision Affects Your Eligibility

You remain eligible for the Essential Plan.

## 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 December 13, 2016 eligibility determination notice is AFFIRMED.

You remain eligible for the Essential Plan.

## Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

## A Copy of this Decision Has Been Provided To:

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.

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