



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

## Notice of Decision

Decision Date: June 12, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015657

[REDACTED]

Dear [REDACTED],

On May 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 6, 2017 preliminary eligibility determination.

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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## Decision

Decision Date: June 12, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015657

[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?

Did NY State of Health properly determine that you were ineligible for Medicaid?

## Procedural History

On February 6, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid, effective February 1, 2016.

Also on February 6, 2016, NYSOH issued a notice of enrollment confirming your enrollment in a Medicaid Managed Care plan, effective March 1, 2016.

On December 3, 2016, NYSOH issued a renewal notice stating that you were eligible for the Essential Plan, effective February 1, 2017.

On December 17, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your Medicaid Managed Care plan would end on January 31, 2017.

Also on December 17, 2016, NYSOH issued an enrollment notice confirming your enrollment in the Essential Plan, effective February 1, 2017.

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On December 19, 2016, you updated your application for financial assistance.

On December 20, 2016, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed in order to determine your eligibility. This notice directed you to submit documentation of your income by January 3, 2017.

On January 5, 2017, you updated your application for financial assistance. Also on January 5, 2017, income documentation was uploaded to your NYSOH account.

On January 6, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed in order to determine your eligibility. This notice directed you to submit documentation of your income by January 3, 2017.

On January 23, 2017, you updated your application for financial assistance.

On January 25, 2017, additional income documentation was uploaded to your NYSOH account.

On February 6, 2017, NYSOH reviewed the income documentation you submitted and updated the income listed in your application based on that documentation. That day, a preliminary eligibility determination was prepared stating that you were eligible to enroll in the Essential Plan, effective March 1, 2017.

On February 8, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not found eligible for Medicaid.

On February 15, 2017, NYSOH determined your eligibility for aid to continue pending the outcome of your appeal. That day, a preliminary eligibility determination was prepared stating that you were eligible for the Essential Plan pending the outcome of your appeal.

On May 23, 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 until June 2, 2017, to allow you to submit supporting documents.

As of June 2, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

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## 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) You testified that you are not sure what your annual expected income is, but you believe it is around \$15,000.00.
- 4) You testified that you currently have one job for which you are paid an hourly wage of \$9.70 per hour and are paid on a weekly basis each Friday. You testified that the amount of hours you work each week varies.
- 5) You testified that you are not sure what your income was in February 2017. The Hearing Officer requested that you submit income documentation for your income in February 2017 by June 2, 2017. No such documentation was submitted by the deadline.
- 6) The application that you submitted on December 19, 2016 listed an annual household income of \$12,015.00. The applications that you submitted on January 5, 2017 and January 23, 2017 listed an annual household income of \$15,669.27.
- 7) On January 5, 2017, you uploaded four paystubs to your NYSOH account. The first is dated December 9, 2016 for a gross pay amount of \$259.19; the second is dated December 16, 2016 for a gross pay amount of \$316.63; the third is dated December 23, 2016 for a gross pay amount of \$310.99; the fourth is dated December 30, 2016 for a gross pay amount of \$652.36.
- 8) On January 26, 2017, you uploaded three paystubs to your NYSOH account. The first is dated January 6, 2017 for a gross pay amount of \$231.53; the second is dated January 13, 2017 for a gross pay amount of \$327.67; and the third is dated January 20, 2017 for a gross pay amount of \$354.80.
- 9) On February 6, 2017, NYSOH redetermined your expected annual income to be \$20,362.68 utilizing the four most recent paystubs you had submitted (December 30, 2016; January 6, 2017; January 13, 2017; January 20, 2017) (\$1,566.36 for four weeks results in an average of \$391.59 for 52 weeks).

10) You testified that you are not sure if you will be able to claim any deductions on your 2017 tax return. You explained that you do have student loans that will be switching from deferred to repayment status.

11) Your application states that you live in Ulster 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).

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

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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 for a one-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 were eligible for the Essential Plan, effective March 1, 2017.

On February 6, 2017, NYSOH recalculated your annual expected income based on the paystubs that you submitted. NYSOH redetermined your annual expected income to be \$20,362.68 utilizing the four most recent paystubs you had submitted (December 30, 2016; January 6, 2017; January 13, 2017; January 20, 2017) (\$1,566.36 for four weeks results in an average of \$391.59 for 52 weeks).

The testimony and documents contained in the record are insufficient to disturb this calculation.

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 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 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 an annual household income of \$20,362.68 is 171.40% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

The second 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 \$12,060.00 for a one-person household. Since \$20,362.68 is 168.84% 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 failed to submit income documentation for February 2017, therefore, your eligibility cannot be determined on the basis of monthly income.

Since the February 6, 2017 preliminary eligibility determination properly stated that, based on the documentation you provided, you were eligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

## **Decision**

The February 6, 2017 preliminary eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** June 12, 2017

## **How this Decision Affects Your Eligibility**

You remain eligible for the Essential Plan.

You are ineligible for Medicaid.

## **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

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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 February 6, 2017 preliminary eligibility determination notice is **AFFIRMED**.

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You remain eligible for the Essential Plan.

You are ineligible for Medicaid.

### **Legal Authority**

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

**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 مجاناً.

### বাংলা (Bengali)

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## **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 okyerE 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.

## **שׂוּדִישׁ (Yiddish)**

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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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