



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

## Notice of Decision

Decision Date: July 6, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000017205

[REDACTED]

Dear [REDACTED]

On June 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 7, 2017 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 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.

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## Decision

Decision Date: July 6, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000017205

[REDACTED]

## Issues

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

Did NY State of Health (NYSOH) properly determine that you were eligible to enroll in the Essential Plan, effective April 1, 2017?

Did NYSOH properly determine that you were not eligible for Medicaid, as of your March 6, 2017 application?

## Procedural History

On March 6, 2017, NYSOH received your updated application for financial assistance.

On March 7, 2017, NYSOH issued an eligibility determination based on the March 6, 2017 application, stating that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective April 1, 2017. It further stated that you no longer qualified for Medicaid as of March 31, 2017,.

On March 23, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not eligible for Medicaid. You also requested Aid to Continue, pending the outcome of your appeal.

On March 25, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid for a limited time, effective April 1, 2017. This

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was because your request for Aid to Continue, pending the outcome of your appeal, had been granted.

Also on March 25, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a Medicaid Managed Care plan, beginning April 1, 2017. This was also because NYSOH granted your request for Aid to Continue, pending the outcome of your appeal.

On June 28, 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 through July 13, 2017 to allow you time to submit supporting documentation.

On June 29, 2017, you uploaded four documents to your NYSOH account. The record is now closed.

## **Findings of Fact**

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

- 1) Your March 6, 2017 application stated that you did not expect to file a tax return for 2017. You testified at the hearing that, now that you are working, you believe you will be filing a 2017 federal income tax return.
- 2) You testified that you expect to file your tax return as single, and will claim no dependents.
- 3) The application that was submitted on March 6, 2017, which requested financial assistance, listed annual household income of \$20,592.00, consisting of income you earn from employment. You testified that this amount was correct.
- 4) You testified that your income may decrease in the fall, as you expect to return to school. However, as of the hearing, you did not have a definite date as to when that would happen.
- 5) You testified that you are paid \$11.00 an hour, and generally work thirty or more hours per week. You testified that you do not earn overtime pay.
- 6) You testified that you do not expect to take any deductions on your 2017 tax return.
- 7) You testified that you are looking to keep your Medicaid coverage because you want to maintain the medical care that you are currently

receiving, as it could be detrimental to your health if this care ended abruptly.

- 8) Your application states that you live in [REDACTED].
- 9) After the hearing, you uploaded four paystubs from the month of March 2017 for the following pay dates and gross earnings:

- a. 3/2/17 - \$391.60 ([REDACTED]);
- b. 3/9/17 - \$391.27 ([REDACTED]);
- c. 3/16/17 - \$391.38 ([REDACTED]);
- d. 3/23/17 - \$391.38 ([REDACTED]).

Taken together, these documents are marked and entered into the record as "Appellant's [REDACTED]."

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>).

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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 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 April 1, 2017.

The application that was submitted on March 6, 2017 listed an annual household income of \$20,592.00, and the eligibility determination relied upon that information.

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

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date of your application, the relevant FPL was \$11,880.00 for a one-person household. Since an annual household income of \$20,592.00 is 173.33% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan, based on your March 6, 2017 application.

The second issue under review is whether NYSOH properly determined that you were not eligible 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 \$20,592.00 is 170.75% 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.

After the hearing, you submitted four paystubs from March 2017 dated March 2, 9, 16, and 23, 2017. A paystub for March 30, 2017 was not received (See Appellant's [REDACTED]).

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. Even though you omitted your March 30, 2017 paystub, the documentation you provided already totals \$1,565.63 in earnings for March 2017. Since this is already over the monthly Medicaid income limit for a household of one, you do not qualify for Medicaid on the basis of monthly income, as of the date of your application.

Since the March 7, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan, it was correct and is AFFIRMED.

## **Decision**

The March 7, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision: July 6, 2017**

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

You remain eligible for the Essential Plan.

You are not eligible 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 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 March 7, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for the Essential Plan.

You are not eligible 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. y&b&tumi 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.

## **שׂוֹדִישׁ (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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