



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

Notice of Decision

Decision Date: July 26, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017263

[REDACTED]

Dear [REDACTED],

On July 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 11, 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.

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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NY State of Health Account ID: [REDACTED]
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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 with a \$20.00 monthly premium, effective April 1, 2017?

Did NYSOH properly determine that you were not eligible for Medicaid, as of March 11, 2017?

Procedural History

On January 27, 2017, NYSOH received your updated application for financial assistance.

On January 28, 2017, NYSOH issued an eligibility determination based on the January 27, 2017 application, stating that you were eligible to enroll in the Essential Plan with no monthly premium for a limited time, effective March 1, 2017. The notice further directed you to provide documentation of your income by April 27, 2017.

On February 9, 2017, you faxed documentation to NYSOH, which was uploaded by NYSOH to your account on March 2, 2017.

On March 10, 2017, NYSOH reran your eligibility, based on the income documentation you provided.

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On March 11, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a monthly premium of \$20.00, based on a household income of \$19,365.45. This eligibility was effective April 1, 2017.

On March 24, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination, insofar as you were not eligible for the Essential Plan with no monthly premium.

On March 25, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan 1 with a \$20.00 monthly premium beginning March 1, 2017.

On July 7, 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 21, 2017 to give you the opportunity to submit a copy of your 2016 W-2(s), and your year-to-date earnings for 2017.

As of July 24, 2017, no further documentation was received by NYSOH's Appeals Unit. The record is now closed.

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 to be eligible for the Essential Plan with no premium, or for Medicaid.
- 3) The application that was submitted on January 27, 2017, which requested financial assistance, listed annual household income of \$17,160.00 consisting of income earned from employment. This application resulted in NYSOH finding you eligible for the Essential Plan with no monthly premium. However, you were required to submit income documentation to support the income information in your application.
- 4) On February 9, 2017, you faxed income documentation to NYSOH as follows:
 - a. A one-page letter from [REDACTED], dated February 7, 2017, stating that you are employed there is a part-time [REDACTED], and that you work approximately seven to seven and a

half hours per week, at a pay rate of \$10.00 per hour (Document [REDACTED]);

- b. A biweekly paystub from [REDACTED], dated January 18, 2017, for gross earnings of \$616.05;
 - c. A biweekly paystub from [REDACTED] dated January 31, 2017 for gross earnings of \$723.60, and showing year-to-date pay of \$1,851.00 [REDACTED]
- 5) On March 10, 2017, NYSOH reviewed this income documentation and calculated your gross annual expected income to be \$19,365.45. NYSOH reran your eligibility, using this income, and determined that you were eligible for the Essential Plan with a \$20.00 monthly premium.
 - 6) You testified that you work approximately twenty-one hours per week for [REDACTED], and earn \$15.00 an hour. You testified that your average weekly gross pay is \$300.00
 - 7) You testified that you work a second job for [REDACTED] one day a week, between four and seven hours, for \$10.00 an hour.
 - 8) You testified that your pay changes regularly, as you sometimes do not work when [REDACTED] takes vacation, and that, if you have to take sick time or vacation time, you do not get paid.
 - 9) You testified that, in 2016, your W2 from [REDACTED] was for \$16,385.00, and for [REDACTED], it was \$5,325.96.
 - 10) You testified that you do not expect your 2017 wages to be as high as they were in 2016 for [REDACTED].
 - 11) Your application states that you will not be taking any deductions on your 2017 tax return.
 - 12) Your application states that you live in [REDACTED].
 - 13) The record was left open after the hearing to give you the opportunity to submit your 2016 W2s, and to submit your year-to-date earnings for both of your jobs for 2017. However, no further documentation was received by NYSOH's Appeals Unit.

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 2017 FPL, which is \$12,060.00 for a one-person household (82 Fed. Reg. 8831).

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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 with a \$20.00 monthly premium, effective April 1, 2017.

You supplied income documentation showing that you earn \$70.00 - \$75.00 per week at one job, and that your average biweekly earnings at your second job are \$669.83. This equates to an expected annual household income of \$21,055.45, utilizing the lower weekly pay rate of \$70.00 for your position with [REDACTED]

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 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 \$11,880.00 for a one-person household. Since an annual household income of \$21,055.45 is 177.23% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

It is noted that NYSOH, for reasons that are unclear, found that your expected annual income from your [REDACTED] job was \$1,950.00. This is clearly an error, as the documentation you provided states that you earn \$70.00 to \$75.00 per week, which equates to \$3,640.00 to \$3,900.00 per year. However, this error did not prevent NYSOH from arriving at the proper eligibility determination, so it is only noted here for the record.

A person who has a household income that is at or below 150% of the FPL has a \$0.00 premium contribution, while 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 \$21,055.45 is 177.23% of the 2016 FPL, NYSOH correctly found you eligible for the Essential Plan with a \$20.00 monthly premium.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid, as of March 11, 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 \$12,060.00 for a one-person household. Since \$21,055.45 is 174.59% 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.

At the hearing, you testified that you believe your annual household income will be lower than what NYSOH calculated it to be. The record was left open to give you the opportunity to submit documentation showing your 2017 income to date. However, no further documentation was submitted to NYSOH. For this reason, there is no basis in the record for modifying the income amount that was determined on the basis of the documentation you provided in February 2017.

Since the March 11, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan with a \$20.00 monthly premium, it was correct and is AFFIRMED.

Decision

The March 11, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: July 26, 2017

How this Decision Affects Your Eligibility

You remain eligible for the Essential Plan with a \$20.00 monthly premium.

You are not eligible for Medicaid, based on the information in the record.

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.

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).

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 11, 2017 eligibility determination notice is **AFFIRMED**.

You remain eligible for the Essential Plan with a \$20.00 monthly premium.

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You are not eligible for Medicaid, based on the information in the record.

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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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।

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 okyer& 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.

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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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