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

Notice of Decision

Decision Date: August 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017967

[redacted]

Dear [redacted],

On August 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: August 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017967

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determined that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective May 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid, as of April 6, 2017?

Procedural History

On April 6, 2017, NYSOH re-ran your application for financial assistance, based on income documentation uploaded to your NYSOH account on March 31, 2017.

On April 7, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective May 1, 2017.

On April 8, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan 1, plus Vision and Dental, beginning May 1, 2017.

On April 11, 2017, you spoke to NYSOH's Account Review Unit and appealed, insofar as you were not eligible for a higher level of financial assistance.

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On August 4, 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 August 21, 2017, to allow you to submit supporting documents.

As of August 22, 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.

Findings of Fact

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

1) Your initial application, filed on February 24, 2017, indicated that you would be filing your 2017 tax return as head of household with qualifying individual, and that you would claim your daughter as your dependent.

2) During the hearing, you testified that your daughter is [redacted], so you do not believe you will be claiming her as a dependent on your 2017 federal income tax return, and that you will be filing with a status of single.

3) On March 31, 2017, you uploaded income documentation to your NYSOH account consisting of two biweekly paystubs for the following dates and gross pay amounts:

    a. March 10, 2017: $1,223.13, after the deduction of your 401K and disability insurance payments;
    b. March 24, 2017: $990.76, after the deduction of your 401K and disability insurance payments;
    (Document [redacted]).

4) NYSOH determined that your expected annual household income was $29,102.84, based on the paystubs you provided.

5) You testified that you are paid $12.08 an hour, and that you generally work 40 hours per week. You testified that you are paid biweekly.

6) You testified that, if you work overtime, you are paid time and a half.

7) Your application states that you will not be taking any deductions on your 2017 tax return.

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

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9) You testified that you cannot afford to pay for the Essential Plan, once you add in the cost of dental and vision coverage.

10) The record was left open after the hearing so that you could submit updated income information. However, no documentation was received by the Appeals Unit by August 22, 2017, and the record was closed.

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).

“Household income” is based on the size of an individuals’ household. For purposes of the Essential Plan, “household size” means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

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 $16,020.00 for a two -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 $16,240.00 for a two-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 with a $20.00 monthly premium, effective May 1, 2017.

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 $16,020.00 for a two-person household.

The eligibility determination issued on April 7, 2017 was based on a two-person household with an expected annual household income of $29,102.84. Since an annual household income of $29,102.84 is 181.67% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan, based on the income documentation and household size indicated in your account.

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 for Essential Plan

coverage. Since an income of $29,102.84 is 181.67% of the FPL, you were found eligible for the Essential Plan with a $20.00 monthly premium.

The second issue under review 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 $16,240.00 for a two-person household. Since $29,102.84 is 181.67% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information available as of April 6, 2017.

Since the April 7, 2017 eligibility determination properly stated that, based on the information in your application, you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, and ineligible for Medicaid, it is correct and is AFFIRMED.

The record was held open after the hearing so that you could provide more current income documentation, but no documentation was received by the Appeals Unit. However, it does appear that NYSOH calculated your income without taking into account the deductions for your 401K and New York State disability insurance payments. Taking those into account, your average biweekly pay, based on the income documents provided, was $1,106.95. This equates to an annual expected income of $28,780.57.

Additionally, you testified that you do not plan to claim your daughter as a dependent when you file your 2017 federal income tax return.

For these reasons, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, based on a one-person household with an expected annual income of $28,780.57, residing in [redacted].

Decision

The April 7, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, based on a one-person household with an expected annual income of $28,780.57, residing in [redacted].

Effective Date of this Decision: August 28, 2017

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).

How this Decision Affects Your Eligibility

You were eligible for the Essential Plan with a $20.00 monthly premium, as of April 6, 2017.

You were not eligible for Medicaid, as of April 6, 2017.

Based on the new information regarding your household size provided at the hearing, your case is being sent back to NYSOH to redetermine your eligibility for financial assistance, based on a one-person household with an expected annual income of $28,780.57 residing in [redacted].

If your household size or income changes again, you may update your application to have your eligibility for financial assistance redetermined.

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

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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):

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- 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 April 7, 2017eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, based on a one-person household with an expected annual income of $28,780.57, residing in [redacted].

You were eligible for the Essential Plan with a $20.00 monthly premium, as of April 6, 2017.

You were not eligible for Medicaid, as of April 6, 2017.

Based on the new information regarding your household size provided at the hearing, your case is being sent back to NYSOH to redetermine your eligibility for financial assistance, based on a one-person household with an expected annual income of $28,780.57 residing in [redacted].

If your household size or income changes again, you may update your application to have your eligibility for financial assistance redetermined.

Legal Authority

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

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A Copy of this Decision Has Been Provided To:

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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।

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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 महत्त्वपूर्ण 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 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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