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

Notice of Decision

Decision Date: October 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019994

[redacted]

Dear [redacted],

On September 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 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
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Albany, NY 12211

Decision

Decision Date: October 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019994

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that you were eligible for the Essential Plan, with a $20.00 per month premium, effective June 1, 2017?

Procedural History

On June 2, 2017, you submitted an application for financial assistance.

On June 3, 2017, NYSOH issued a notice stating that the income information in your application does not match federal and state data sources. You were directed to provide proof of household income by June 17, 2017.

On June 5, 2017, you submitted income documentation.

On June 6, 2017, an application for financial assistance with health insurance was submitted on your behalf.

On June 7, 2017, NYSOH issued a notice of eligibility determin[redacted] stating that you were eligible for the Essential Plan with a $20.00 per month premium, effective June 1, 2017.

On June 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination, insofar as you were seeking the Essential Plan with a $0.00 per month premium.

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On June 28, 2017, an application was run on your behalf.

On June 29, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a $0.00 premium for a limited time, effective June 1, 2017, because you had been granted aid to continue until a decision is made on your appeal.

Also on June 29, 2017, NYSOH issued an enrollment confirmation notice, stating that you were enrolled in the Essential Plan, effective June 1, 2017.

On September 22, 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 up to October 6, 2017, to allow you to submit supporting documents.

On October 2, 2017, you submitted supporting documentation. It was entered into the record as Appellant's "Exhibit #1." The record remained open and was closed on October 6, 2017.

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, specifically the Essential Plan with a $0.00 per month premium.

3) The application that was submitted on June 6, 2017 listed annual household income of $19,292.00, consisting of income you earn from your employment. You testified that this amount was incorrect.

4) You testified that you work under contract for [redacted], earning $15,582.05 annually plus a $300 per year stipend. You testified that you are paid $742.00 biweekly from September to June.

5) On June 5, 2017, you submitted two paystubs:
    a. dated May 12, 2017 for a gross $742.00
    b. dated May 26, 2017 for a gross $742.00

6) On October 2, 2017, you submitted additional paystubs:
    a. dated June 23, 2017 for a gross $1,932.45, which included a $300 stipend

b. dated September 29, 2017 for a gross $593.60, which indicates that this was the first paycheck of the fiscal year

7) Each paycheck indicates a contract value of $15,582.05.

8) You testified that you expect to earn the same in 2017 as you earned in 2016.

9) You submitted your 2016 1040, which states that you earned $15,369.00 in wages and $18,696.00 in taxable pensions and annuities.

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

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

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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan with a $20.00 per month premium, effective June 1, 2017.

The application that was submitted on June 6, 2017 listed an annual household income of $19,292.00 and the eligibility determination relied upon that information. This income was reasonably calculated using the paystubs you provided ($742.00 x 26 biweekly paychecks).

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. 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). On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $19,292.00 is 162.4% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan with a $20.00 per month premium.

Since the June 7, 2017 eligibility determination properly stated that, based on the information in the application, you were eligible for the Essential Plan with a $20.00 per month premium, it is correct and is AFFIRMED.

During the hearing, you credibly testified that because you work for [redacted], you are not paid for all fifty-two weeks of the year. You further submitted paystubs that state a contract value of $15,582.05, which also differentiate between the fiscal year-to-date and the calendar year-to-date. You submitted a paystub dated September 29, 2017, which clearly indicates that it is the first paycheck of the fiscal year. However, you also submitted your 2016 1040 which lists taxable pension and annuity income that was not included in your testimony

or application, and testified that you expect to earn about the same in 2017 as you did in 2016. Therefore, based on your documentation and testimony, there is insufficient information in the record to recalculate your income and return your case for redetermination. If the information listed in your application is incorrect, please update your account accordingly.

Decision

The June 7, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 27, 2017

How this Decision Affects Your Eligibility

You were properly determined eligible for the Essential Plan with a $20.00 per month premium.

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 June 7, 2017 eligibility determination notice is AFFIRMED.

You were properly determined eligible for the Essential Plan with a $20.00 per month premium.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

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.

□□□□□ (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 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)

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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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