



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

## Notice of Decision

Decision Date: September 28, 2017

NY State of Health Account ID [REDACTED]  
Appeal Identification Number: AP000000020187

[REDACTED]

Dear [REDACTED],

On September 25, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 20, 2017 eligibility determination notice.

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.

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## Decision

Decision Date: September 28, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000020187

[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 your household was eligible for the Essential Plan 1 with a \$20.00 monthly premium per person, effective August 1, 2017?

Did NY State of Health properly determine that your household was not eligible for Medicaid?

## Procedural History

On June 19, 2017, you submitted an application for financial assistance with your health insurance for your household.

On June 20, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you, your wife, and your two children were eligible for the Essential Plan for a cost of \$20.00 per month, effective August 1, 2017. That notice also stated that you were not eligible for Medicaid because your income was over the allowable income limit for that program.

On July 1, 2017, you spoke to NYSOH's Account Review Unit and appealed the June 20, 2017 eligibility determination notice insofar as your household was not eligible for the Essential Plan 2 for a cost of \$0.00 per month.

On September 25, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and

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held open up to October 10, 2017, to allow you time to submit supporting documents.

On September 26, 2017, NYSOH received your supporting documentation in the form of an 8-page fax and has been incorporated into the record as Appellant's Exhibit 1. The record was closed that day since you had provided all necessary documentation as requested at the time of your hearing.

## **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 married filing jointly. You will claim two dependents on that tax return.
- 2) You are seeking insurance for yourself, your wife, and your two children.
- 3) The application that was submitted on June 19, 2017, listed annual household income of \$40,942.66, consisting of \$5,000.00 you earn from your employment and \$26,712.00 your spouse receives in earned income. You testified that this amount was incorrect.
- 4) You testified that you believe your household income will be much less because you lost your employment in March 2017, and now collect unemployment insurance benefits.
- 5) You provided a copy of your unemployment insurance benefits statement showing you received in June 2017 \$355.00 per week for a total of \$1,065.00 (See Appellant's Exhibit 1, pg. 8)
- 6) You provided copies of your wife's weekly paystubs for the month of June 2017, showing that in June 2017 she earned \$2,094.00. She received four paystubs with check dates of 6/8, 6/15, 6/22, and 6/29, in the amounts of \$558.00, \$576.00, \$384.00, and \$576.00 (See Appellant's Exhibit 1 pgs. 2-6).
- 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], NY.

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 \$24,300.00 for a four-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

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)).

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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 \$24,600.00 for a four-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 your household was eligible for the Essential Plan 1 with a \$20.00 premium per person, effective August 1, 2017.

The application that was submitted on June 19, 2017, listed an annual household income of \$40,942.66 and the eligibility determination relied upon that information.

You are in a four-person household. You expect to file your 2017 income taxes as married filing jointly and will claim two 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 \$24,300.00 for a four-person household. 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 \$40,942.66 is 168.48% of the 2016 FPL, NYSOH properly found your household to be eligible for the Essential Plan 1 with a \$20.00 premium.

The second issue is whether NYSOH properly determined that your household was 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 \$24,600.00 for a four-person household. Since \$40,943.00 is 166.43% of the 2017 FPL, NYSOH properly found your household to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

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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 provided a copy of your unemployment insurance benefits statement showing you received a total of \$1,065.00, and your spouse earned \$2,094.00 in earned income in June 2016.

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 \$2,829.00 per month. Since the documentation you provided shows that you had a household income of \$3,159.00 in June 2017 your household does not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the June 20, 2017, eligibility determination notice properly stated that, based on the information you provided, your household was eligible for the Essential Plan 1, for a cost of \$20.00 per month, and ineligible for Medicaid, it is correct and is AFFIRMED.

## **Decision**

The June 20, 2017, eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** September 28, 2017

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

Your household is eligible for the Essential Plan 1 for a cost of \$20.00 per month.

Your household is ineligible for the Essential Plan 2.

Your household is 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

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## **Summary**

The June 20, 2017, eligibility determination notice is AFFIRMED.

Your household is eligible for the Essential Plan 1 for a cost of \$20.00 per month.

Your household is ineligible for the Essential Plan 2.

Your household is 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)

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 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 srε wo, frε 1-855-355-5777. ye&εtumi ama wo obi a okyerε 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 דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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