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

# Notice of Decision

Decision Date: March 30, 2018

NY State of Health Account ID
Appeal Identification Number: AP000000026926

Dear ,

On March 22, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 15, 2017 eligibility determination notice and January 6, 2018 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.

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: March 30, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000026926

## Issue

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

> Did NY State of Health properly determine that you were eligible for the Essential Plan?

## Procedural History

On December 12, 2017, you applied for health insurance and financial assistance through NY State of Health (NYSOH).

On December 13, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to provide proof of your household income by December 27, 2017 in order for your eligibility for financial assistance to be determined.

On December 14, 2017, you uploaded income documentation to your NYSOH account.

Also on December 14, 2017, NYSOH reviewed the income documentation you submitted, recalculated your annual expected income based on this documentation, and submitted an application on your behalf.

On December 15, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan, effective January 1, 2018.

On December 26, 2017, you updated your application for financial assistance with health insurance and uploaded income documentation to your NYSOH account.

Additionally, on December 26, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On December 27, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to provide proof of your household income by January 10, 2018 in order for your eligibility for financial assistance to be determined.

Also on December 27, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional documentation was due by January 10, 2018.

On January 4, 2018, you updated your application for financial assistance with health insurance.

Also on January 4, 2018, you uploaded income documentation to your NYSOH account.

On January 5, 2018, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice directed you to provide proof of your household income by January 10, 2018 in order for your eligibility for financial assistance to be determined.

Also on January 5, 2018, NYSOH reviewed the income documentation you submitted, recalculated your annual expected income based on this documentation, and submitted an application on your behalf.

On January 6, 2018, NYSOH issued an eligibility determination notice stating that you were for the Essential plan, effective February 1, 2018. That notice also

stated that you were not eligible for Medicaid because your annual household income was over the allowable income limit for that program.

On January 8, 2018, you spoke to NYSOH's Account Review Unit and appealed those eligibility determination notices insofar as you were not found eligible for Medicaid as of January 1, 2018.

On March 22, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, appeared as your attorney. The record was developed during the hearing and closed at the end of the hearing.

## Findings of Fact

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

1) Your attorney stated that you are seeking to be found eligible for Medicaid as of January 1, 2018. It is his position that NYSOH improperly calculated your income based on fifty-two (52) weeks of earnings rather than actual number of weeks worked.

2) You attorney stated that you expect to file your tax return for 2018 with a tax filing status of single, that you will not claim any dependents on that return, and that no one will claim you as a dependent on their tax return for that year.

3) Your attorney stated that you have two employers, , that you are paid on a biweekly basis by on a weekly basis by , and that you work between thirty-six and forty-two weeks per year as you do not work during July or August, or .

4) Your attorney stated you have no income other than your income from employment.

5) The application that was submitted on December 12, 2017 listed annual household income of $14,600.00, consisting of $6,000.00 from from January 1, 2018 through June 30, 2018, $3,600.00 from from September 1, 2018 through December 15, 2018, $3,125.00 from from January 1, 2018 through June 30, 2018, and $1,875.00 from from September 1, 2018 through December 15, 2018.

6) On December 14, 2017 you uploaded income documentation to your NYSOH account consisting of;

a. Your 2016 tax return showing total income of $4,019.00 and adjusted gross income of $4,019.00;
b. Six paystubs from
    i. The first is for pay date September 19, 2017 for a gross pay amount of $240.00;
    ii. The second is for pay date October 4, 2017 for a gross pay amount of $360.00;
    iii. The third is for pay date October 17, 2017 for a gross pay amount of $400.00;
    iv. The fourth is for pay date October 31, 2017 for a gross pay amount of $480.00;
    v. The fifth is for pay date November 14, 2017 for a gross pay amount of $640.00;
    vi. The sixth is for pay date November 28, 2017 for a gross pay amount of $320.00;
c. Six paystubs from
    i. The first is for pay date September 27, 2017 for a pay amount of $227.30;
    ii. The second is for pay date October 11, 2017 for a pay amount of $112.18;
    iii. The third is for pay date October 25, 2017 for a pay amount of $227.36;
    iv. The fourth is for pay date November 8, 2017 for a pay amount of $227.36;
    v. The fifth is for pay date November 22, 2017 for a pay amount of $112.18;
    vi. The sixth is for pay date December 6, 2017 for a pay amount of $227.36

7) On December 14, 2017, NYSOH reviewed the income documentation you submitted and recalculated your annual expected income. NYSOH recalculated your income from to be $12,480.00 annually.

8) Also on December 14, 2017, NYSOH updated your application to reflect annual expected income of $17,480.00 consisting of $12,480.00 annually from , $3,125.00 from from January 1, 2018 through June 30, 2018, and $1,875.00 from from September 1, 2018 through December 15, 2018.

9) The application you submitted on December 26, 2017 listed annual income of $5,475.00 consisting of $3,600.00 from from January 1, 2017 through December 15, 2017 and $1,875.00 from from January 1, 2017 through December 15, 2017.

10) On December 26, 2017, you reuploaded the income documentation you submitted on December 14, 2017.

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11) Also on December 26, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account as the checks from [redacted] were not paystubs, and the required documentation was a letter signed and dated by your employer showing your gross pay and frequency.

12) The application you submitted on January 4, 2018 listed annual income of $5,475.00 consisting of $3,600.00 from [redacted] from January 1, 2017 through December 15, 2017 and $1,875.00 from [redacted] from January 1, 2017 through December 15, 2017.

13) On January 4, 2017, you submitted a letter from [redacted] dated January 2, 2018 stating that your gross weekly salary was $240.00 and that you only worked when [redacted] and that you do not work during July, August, [redacted]. You also submitted a letter from [redacted] stating that your gross weekly salary was $125.00 and that you do not work during July, August, [redacted].

14) On January 5, 2018, NYSOH reviewed the income documentation you submitted and recalculated your annual expected income to be $18,980.00, consisting of $12,480.00 from [redacted] annually and $6,500.00 from [redacted] annually.

15) Your applications state that you will not be taking any deductions on your 2018 tax return.

16) Your applications state that you live in Richmond County.

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 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

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

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/downloads/ny-blueprint.pdf).

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)).

<u>Medicaid</u>

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 December 2017 applications, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

On the date of your January 2018 applications, that was the 2018 FPL, which is $12,140.00 for a one-person household (83 Fed. Reg. 2642).

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 issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan.

You expect to file your 2018 income tax return as single and will not claim any dependents on that return. Therefore, you are in a one-person household.

On December 14, 2017, NYSOH validated your paystubs as satisfactory documentation of your income and an application for financial assistance was run on your behalf by an NYSOH representative. The NYSOH representative entered into your application earned income of $17,480.00 consisting of $12,480.00 annually from , $3,125.00 from from January 1, 2018 through June 30, 2018, and $1,875.00 from from September 1, 2018 through December 15, 2018.

In the application you submitted on December 12, 2017, you indicated that you would work for from January 1, 2018 through June 30, 2018 and from September 1, 2018 through December 15, 2018.

NYSOH calculated annual income from by utilizing the four most recent weeks' paystubs which indicated gross earnings of $960.00, divided by four weeks for a weekly average of $240.00, multiplied by 52 weeks for a total of $12,480.00.

However, as the information in your application reflected that you were a forty-week worker, NYSOH miscalculated your annual expected income from . Utilizing the two most recent biweekly paystubs you had submitted, your annual expected income from was $9,600.00.

Therefore, the December 14, 2017 application erroneously utilized 52 weeks of pay rather than the forty weeks you actually work.

Since the December 15, 2017 eligibility determination is not supported by the documentation you provided as well as your application and your attorney's statements during the hearing it is RESCINDED.

On January 5, 2018, NYSOH validated letters from your employers as satisfactory documentation of your income and an application for financial assistance was run on your behalf by an NYSOH representative. The NYSOH representative entered into your application $18,980.00, consisting of $12480.00 from annually and $6,500.00 from annually.

NYSOH calculated annual income from by utilizing the gross weekly pay listed in the letter from your employer of $240.00 and multiplying by 52 weeks for

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a gross annual pay of $12,480.00. NYSOH calculated your annual income from [redacted] by utilizing the gross weekly pay listed in the letter from your employer of $125.00 and multiplying by 52 weeks for a gross annual pay of $6,500.00.

However, both the letters from your employers indicate that you do not work during the months of July and August [redacted].

Therefore, the January 5, 2018 application erroneously utilized 52 weeks of pay rather than the forty weeks you actually work.

Since the January 6, 2018 eligibility determination is not supported by the documentation you provided as well as your application and your attorney's statements during the hearing it is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 14, 2017 based on a one-person household residing in Richmond County with an annual expected income of $14,600.00 (40 weeks worked at $240.00 per week and 40 weeks worked at $125.00 per week), and to allow you to select a plan for enrollment as though you had selected a plan on December 14, 2017.

## Decision

The December 15, 2017 eligibility determination notice is RESCINDED.

The January 6, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 14, 2017 based on a one-person household residing in Richmond County with an annual expected income of $14,600 (40 weeks worked at $240.00 per week and 40 weeks worked at $125.00 per week), and to allow you to select a plan for enrollment as though you had selected a plan on December 14, 2017.

## Effective Date of this Decision: March 30, 2018

## How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility based on the income documentation you provided as well as information provided during your hearing.

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## If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 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).

## 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 December 15, 2017 eligibility determination notice is RESCINDED.

The January 6, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of December 14, 2017 based on a one-person household residing in Richmond County with an annual expected income of $14,600 (40 weeks worked at $240.00 per week and 40 weeks worked at $125.00 per week), and to allow you to select a plan for enrollment as though you had selected a plan on December 14, 2017.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility based on the income documentation you provided as well as information provided during your hearing.

## Legal Authority

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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.

## (Urdu)اردو

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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