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

Notice of Decision

Decision Date: May 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028467

[redacted]

Dear [redacted]

On April 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 1, 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 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: May 11, 2018

NY State of Health Account ID: [redacted]
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[redacted]

Issues

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

> Did NYSOH properly determine that you were eligible to enroll in the Essential Plan effective March 1, 2018?
>
> Did NYSOH properly determine that you were not eligible for Medicaid, as of January 31, 2018?

Procedural History

On January 31, 2018, NYSOH received your updated application for financial assistance.

On February 1, 2018, NYSOH issued an eligibility determination based on the January 31, 2018 application, stating that you are eligible to enroll in the Essential Plan with a $20.00 premium per month, effective March 1, 2018.

On February 5, 2018, 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 2, which does not require a $20.00 premium per month.

On April 12, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing left open

for 15 days to allow you the opportunity to submit documentation regarding your and your spouse's income.

On April 26, 2018, the Appeals Unit received via upload a letter from your employer stating your income for January, 2018, your weekly income after you decreased your hours beginning [redacted], and your spouse's two bi-weekly paystubs from January, 2018. The documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. 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 2018 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.

3) The application that was submitted on January 31, 2018, which requested financial assistance, listed annual household income of $37,760.00, consisting of $12,800.00 you earn from your employment and $24,960.00 that your spouse receives in income.

4) You testified that your income is incorrect because your hours decreased beginning in January, 2018.

5) On April 26, 2018, you uploaded a letter from your employer, stating that as of [redacted], you reduced your workdays from four days per week to two days per week, resulting in earnings ranging from $80.00 to $150.00 per week. In this letter, you employer further stated that you made $1,240.00 for the month of January from your employment with that company. (*see* Document [redacted]

6) On April 26, 2018, you also uploaded two bi-weekly paystubs from your spouse's employer. The first paystub, dated January 4, 2018, and covering the pay period for December 18, 2017 to December 31, 2017, shows gross earnings of $944.00 (*see* Document [redacted] The second paystub, dated January 18, 2018, and covering the pay period for January 1, 2018 to January 14, 2018, shows gross earnings of $1,040.00. (*see* Document [redacted]

7) Your January 31, 2018 application states that you will be taking a deduction of $800.00 on your 2018 tax return. However, you testified that

you do not expect to take any deductions for 2018 because you are reducing your hours to become a full-time student.

8) Your application states that you live in New York 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 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 2017 FPL, which is $24,600.00 for a four-person household (82 Fed. Reg. 8831, 8832).

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* 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)).

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 2018 FPL, which is $25,100.00 for a four-person household (83 Fed. Reg. 2642, 2643).

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 with a $20.00 premium per month, effective March 1, 2018.

The application that was submitted on January 31, 2018 listed an annual household income of $37,760.00 and the eligibility determination relied upon that information.

You are in a four-person household. You expect to file your 2018 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 (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 $24,600.00 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 $37,760.00 is 153.50% of the 2017 FPL, NYSOH properly found you to be eligible for the Essential Plan with a $20.00 premium per month.

The second issue is whether NYSOH properly determined that you were not eligible 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 $25,100.00 for a four-person household. Since $37,760.00 is 150.44% of the 2018 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

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 submitted a letter from your employer showing that in January, 2018 you earned $1,240.00. You also submitted paystubs from your spouse's employer showing that in the month of January, 2018, he earned an additional $1,984.00.

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 $2,887.00 per month. Since the documentation you provided shows that you earned $3,224.00 in January, 2018, you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the February 1, 2018 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan with a $20.00 premium per month and not eligible for Medicaid, it was correct and is AFFIRMED.

However, at the hearing you testified that your annual household income is different from what was attested to in your application on January 31, 2018. On April 26, 2018, you uploaded income documentation to your NYSOH account showing that after [redacted], your weekly income decreased to a range of $80.00 to $150.00 per week. Given this income range, you now expect to earn an average of $115.00 per week, or $230.00 per bi-weekly period. As a result, you expect to earn $498.33 per month for eleven months, or $5,481.67. In addition, the letter from your employer that you uploaded on April 26, 2018 stated that you earned an additional $1,240.00 in January, 2018, for a total of $6,721.67 in anticipated income for yourself in 2018.

In addition, you uploaded two bi-weekly paystubs for your husband in January, 2018. The first paystub shows gross earnings of $944.00, and the second paystub, dated January 18, 2018, shows gross earnings of $1,040.00, for average gross earnings of $992.00 per bi-weekly period, or $25,792.00 per year.

When added to your own anticipated income of $6,721.67, your anticipated household income for 2018 is $32,513.66.

Since the record now contains a more accurate representation of what your expected annual household income is, your case is RETURNED to NYSOH to redetermine your eligibility for 2018 coverage based on a four-person household, residing in New York County with an annual household income of $32,513.66.

Decision

The February 1, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for 2018 coverage based on a four-person household, residing in New York County with an annual household income of $32,513.66.

Effective Date of this Decision: May 11, 2018

How this Decision Affects Your Eligibility

You remain eligible for the Essential Plan.

You are not eligible for Medicaid as of January 31, 2018.

Your case is being sent back to NYSOH to redetermine your eligibility for 2018 coverage based on the information you provided during your hearing.

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 February 1, 2018 eligibility determination notice is AFFIRMED.

You remain eligible for the Essential Plan.

You are not eligible for Medicaid.

Your case is RETURNED to NYSOH to redetermine your eligibility for 2018 coverage based on a four-person household, residing in New York County with an annual household income of $32,513.66.

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.

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।

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).

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 नि:शुल्क 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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