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

Notice of Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028969

[redacted]

[redacted]

On April 11, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 15, 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
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Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028969

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you were eligible for the Essential Plan with a $20.00 monthly premium?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On February 9, 2018, you uploaded income documentation to your NYSOH account and updated your application for financial assistance.

On February 10, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan for a limited time, effective March 1, 2018. The notice directed you to provide documentation confirming your income before March 18, 2018.

Also on February 10, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan, effective March 1, 2018.

On February 12, 2018, you uploaded income documentation to your NYSOH account.

On February 13, 2018, NYSOH verified the documents you uploaded on February 9, 2018 and February 12, 2018, and determined they were sufficient proof of your income. That same day, a NYSOH representative recalculated your

income based on this information, updated the income in your application based on this recalculation, and then submitted an application on your behalf.

On February 14, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a $20.00 per month premium, effective March 1, 2018.

Also on February 14, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan beginning March 1, 2018.

On February 15, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not eligible for Medicaid.

On April 11, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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) You are seeking health insurance for yourself.

2) You testified that you expect to file your tax return for 2018 with a tax filing status of single, and that you will not claim any dependents on that tax return.

3) The application that was submitted on February 13, 2018, stated annual household income of $21,511.25, consisting of $13,968.00 you earn from your employment at [redacted]., and $7,543.25 you earn form your employment at [redacted]

4) NYSOH determined your 2018 annual income would be $21,511.25, based on paystubs you submitted for yourself.

5) You testified that your income is incorrect because it assumes you work weekly. You further testified that you are a per diem employee at both of your jobs and, therefore, you do not work every week or regular hours per week. You further testified that your work schedule depends on the needs of your employers.

6) You uploaded a letter you wrote to NYSOH, dated February 11, 2018, stating that you are employed as a per diem employee with both [redacted]

[redacted] which letter was verified by NYSOH on February 13, 2018 (*see* Document [redacted].

7) You uploaded a copy of a letter, dated December 22, 2017, from [redacted], which states that you are a per diem employee (*see* Document [redacted]

8) You testified that your final paystubs, which show your gross earnings for the year, are a better reflection of your income because it accounts for the fluctuations in each week. You further testified that you believe your 2018 household income will be approximately the same as it was in 2017.

9) You uploaded a copy of your paystub from [redacted]., dated December 29, 2017, which reflects a gross income of $12,380.98 (*see* Documents [redacted]. You testified that this was your final paystub from [redacted]. for 2017.

10) You uploaded a copy of your paystub from [redacted], dated December 29, 2017, which reflects a gross income of $3,168.00. You testified that this was your final paystub from [redacted] for 2017 (*see* Documents [redacted]

11) Your application states that you will not be taking any deductions on your 2018 tax return.

12) 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 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 $12,060.00 for a one-person household (82 Federal Register 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)).

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 $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 first issue under review is whether NYSOH properly determined you were eligible for the Essential Plan with a $20.00 monthly premium.

On February 9, 2018 and February 12, 2018, you uploaded income documentation to your NYSOH account. On February 13, 2018, a NYSOH representative reviewed the income documentation you submitted and recalculated your household income based on that documentation. An application for financial assistance was submitted on your behalf that day based on earned income of $21,511.25 as calculated by a NYSOH representative. The eligibility determination relied on that information.

You are in a one-person household for the purposes of this analysis. This is because you expect to file your 2018 income tax return as single and you will not claim any dependents on that tax return.

The Essential Plan is generally 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.

On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since an annual household income of $21,511.25 is 178.37% of the 2017 FPL of $12,060.00, NYSOH correctly found you to be 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 $12,140.00 for a one-person household. Since $21,511.25 is 177.19% of the 2018 FPL, NYSOH properly found you were ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Since the February 15, 2018 eligibility determination notice properly stated that, based on the income information you provided and the income as calculated by NYSOH, you were eligible for the Essential Plan with a $20.00 monthly premium and ineligible for Medicaid, it is correct and is AFFIRMED.

However, you testified that an annual household income of $21,511.25 was incorrect because the calculation upon which your income was based assumed

that you work consistently every week, when you testified that you do not. You further testified that you are a per diem employee at both work places and you do not work consistent hours or every week such that your weekly income fluctuates. You submitted documentary evidence that corroborates your testimony.

You uploaded a letter you wrote to NYSOH, dated February 11, 2018, stating that you are employed as a per diem employee with both [redacted] That letter was verified by NYSOH on February 13, 2018. You uploaded a letter, dated December 22, 2017, from [redacted] which also states that you are a per diem employee.

You testified that you believe your final paystubs in 2017 from your employers is a more accurate representation of your income because it accounts for the fluctuation in your household's monthly income. You further testified that you believe your household income will be approximately the same in 2018. You provided copies of your final paystubs from both of your employers for 2017 that show that your annual household income for that year was $15,548.98 (the sum of $12,380.98 and $3,168.00).

Since a more accurate representation of your income I snow available, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance using an annual expected income of $15,548.98 and a one-person household, for an individual residing in Queens County, and to notify you of the new determination accordingly.

Decision

The February 15, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance using an annual expected income of $15,548.98 and a one-person household, for an individual residing in Queens County, and to notify you of the new determination accordingly.

Effective Date of this Decision: April 19, 2018

How this Decision Affects Your Eligibility

NYSOH properly determine you to be eligible for the Essential Plan with a $20.00 monthly premium based on the information in your NYSOH account at the time.

This is not a final determination of your eligibility for financial assistance. Your case is being sent back to NYSOH to redetermine your eligibility based on the

parameters noted above. NYSOH will notify you of the new determination once made.

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 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 15, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance using an annual expected income of $15,548.98 and a one-person household, for an individual residing in Queens County, and to notify you of the new determination accordingly.

NYSOH properly determine you to be eligible for the Essential Plan with a $20.00 monthly premium based on the information in your NYSOH account at the time.

This is not a final determination of your eligibility for financial assistance. Your case is being sent back to NYSOH to redetermine your eligibility based on the parameters noted above. NYSOH will notify you of the new determination once made.

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।

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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 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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