



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

Notice of Decision

Decision Date: March 9, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013034

[REDACTED]

Dear [REDACTED],

On February 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 10, 2016 eligibility redetermination notice.

The enclosed Decision, rendered after that hearing, is issued by the Appeals Unit of the 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 the NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification Number at the top of this letter.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(b).

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).

This page intentionally left blank.



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

Decision

Decision Date: March 9, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000013034



Issues

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

Did New York State of Health properly determine that you were eligible to enroll in the Essential Plan as of October 10, 2016?

Did New York State of Health properly determine that you were not eligible for Medicaid as of October 10, 2016?

Procedural History

On September 16, 2016, your financial assistance application was submitted through New York State of Health (NYSOH).

On September 17, 2016, NYSOH issued a notice stating that your application for health insurance was reviewed, but the income information in your application does not match what NYSOH received from state and federal data sources. The notice requested that provide additional proof of income before September 25, 2016.

On September 19, 2016, you faxed your U.S. Certificate of Naturalization and two biweekly earnings statements to NYSOH (see Documents [REDACTED] and [REDACTED]).

On October 4, 2016, three biweekly earnings statements were uploaded to your NYSOH account (see Documents [REDACTED] and U162786711612).

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).

On October 5, 2016, NYSOH issued a notice stating that your application for health insurance was reviewed, but the income information in your application does not match what NYSOH received from state and federal data sources. The notice requested that provide additional proof of income before October 10, 2016 and proof of citizenship status by January 2, 2017.

On October 6, 2016, your NYSOH account was updated.

On October 10, 2016, NYSOH issued an eligibility redetermination notice that stated you were eligible to enroll in the Essential Plan effective as of November 1, 2016.

On October 12, 2016, NYSOH issued an enrollment notice confirming that stated, as of October 11, 2016, you were enrolled in an Essential Plan with an enrollment start date of November 1, 2016.

On November 2, 2016, you spoke with NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance you were determined eligible to receive.

On February 13, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and was closed at the end of the proceeding.

Findings of Fact

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

1. According to your NYSOH account, you were applying for health insurance through NYSOH for yourself.
2. According to your NYSOH account and testimony, you expected to file your 2016 federal income tax return using the tax status of Head of Household (with qualifying individual), and expected to claim one dependent on that tax return.
3. On October 4, 2016, you submitted three biweekly earnings statements from your employer, [REDACTED]. According to those earning statements, you were issued:
 - (a) \$1,144.55 in gross pay on August 26, 2016;
 - (b) \$1,103.18 in gross pay on September 9, 2016;
 - (c) \$1,103.18 in gross pay on September 23, 2016

(see Documents [REDACTED] and [REDACTED]).

4. You testified, that you are consistently issued \$1,103.18 in gross pay biweekly by your employer.
5. According to your NYSOH account and testimony, your average monthly income is the same as your current month's income.
6. You testified that you paying back your student loans at a rate of \$50.00 per month, including interest on those loans.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, interest on a qualified educational loan can be deducted from adjusted gross income in an amount up to \$2,500 in interest paid by taxpayers during the taxable year, whose yearly income does not exceed \$160,000 (26 USC § 221; see also 26 USC § 62 (17)).

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 2015 FPL, which is \$15,930.00 for a two-person household (80 Fed. Reg. 3236, 3237).

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).

Medicaid:

Medicaid can be provided through the Marketplace 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)), N.Y. Soc. Serv. 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 2016 FPL, which is \$16,020.00 for a two-person household (81 Fed. Reg. 4036).

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 on October 10, 2016 that you were eligible for the Essential Plan as of November 1, 2016.

You expected to file your 2016 federal tax return using the tax status of Head of Household (with qualifying individual), and expected to claim one dependent on

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).

that return. Therefore, you are in a two-person household for purposes of this analysis.

You submitted to NYSOH biweekly earnings statements from your employer. Based on the documentation submitted, NYSOH calculated your household to be \$29,220.49 ($(\$1,144.55 + \$1,103.18) \times 13$).

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 \$15,930.00 for a two-person household. Since \$29,220.49 is 183.43% of the 2015 FPL, NYSOH properly found you to be eligible to enroll in the Essential Plan.

However, you testified that you are consistently issued \$1,103.18 in gross pay biweekly by your employer. Even considering that you pay \$50.00 per month toward your student loans, which could be in interest, your 2016 gross household income would be, at best, \$28,682.68 ($\$1,103.18 \times 26$ biweekly payments), and your adjusted gross income would be \$28,082.68 ($\$28,682.68 - \600.00 in student loan interest).

Since a two-person household with household income of \$28,082.68 is 176.29% of the 2015 FPL, you remain eligible to enroll in the Essential Plan. Therefore, your case will not be returned to NYSOH to recalculate your eligibility for financial assistance.

The second issue under review is whether NYSOH properly determined that were not eligible for Medicaid as of October 10, 2016.

Medicaid can be provided through the Marketplace to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size.

On the date of your application, the relevant FPL was \$16,020.00 for a two-person household. Since \$28,082.68 is 175.30% of the 2016 FPL, NYSOH properly found you to be not eligible for Medicaid on an expected annual income basis.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid is based on current monthly household income and family size. To be eligible for Medicaid on a monthly income basis, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is \$1,843.00 per month.

The record reflects that your average monthly income is the same as your currently monthly income. Since your annual income is \$28,082.68, your monthly income was \$2,340.22 (\$28,082.68/12), which exceeds the limit of \$1,843.00 for a two-person household. Therefore, you would not be eligible for Medicaid on a monthly income basis.

Therefore, NYSOH properly found you eligible to enroll in the Essential Plan and not eligible for Medicaid such that the October 10, 2016 eligibility redetermination notice was correct and is AFFIRMED.

Decision

The October 10, 2016 eligibility redetermination notice is AFFIRMED.

Effective Date of this Decision: March 9, 2017

How this Decision Affects Your Eligibility

You remain eligible to enroll in the Essential Plan.

You remain not eligible for Medicaid.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 after the date 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 U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c))

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

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).

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 October 10, 2016 eligibility redetermination notice is AFFIRMED.

.

You remain eligible to enroll in the Essential Plan.

You remain not eligible for Medicaid.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

A Copy of this Decision Has Been Provided To:

