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

Notice of Decision

Decision Date: July 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016100

[redacted]

Dear [redacted]

On June 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 6, 2017 eligibility determination.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: July 18, 2017

NY State of Health Account ID: [redacted]
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Issues

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

> Did NY State of Health properly determine you were conditionally eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective February 1, 2017?
>
> Did NY State of Health properly determine you were not eligible for Medicaid?

Procedural History

On January 5, 2017, you submitted an application for financial assistance.

On January 6, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, for a limited time, effective February 1, 2017. The notice directed you to submit proof of your income by April 5, 2017 to confirm the income information listed in your application or you might lose your insurance or receive less help paying for your coverage.

Also on January 6, 2017, NYSOH issued an enrollment notice, based on your January 5, 2017 plan selection, confirming your enrollment in an Essential Plan with a $20.00 monthly premium, effective February 1, 2017.

On February 22, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not eligible for Medicaid.

On June 8, 2017, 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 submitted your initial application for financial assistance with health insurance to NYSOH on January 5, 2017. You testified you completed the application yourself online.

2) You testified, and your application indicates, you expect to file your 2017 taxes with a tax filing status of single and you will claim no dependents on that tax return.

3) The application listed an annual household income of $21,840.00, consisting of income earned from your employment at a rate of $12.00 an hour and 35 hours per week. You testified that this amount was correct.

4) You testified you consistently work the same number of hours at the same pay rate each week.

5) Your application lists your monthly income for the month of January 2017 as $1,680.00. You testified this amount was correct.

6) NYSOH calculated your average monthly income to be $1,820.00 based on the information you provided in the application including your pay rate and number of hours worked weekly.

7) Your application states you will not be taking any deductions on your 2017 tax return.

8) Your application indicates you live in [redacted]

9) You were determined conditionally eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective February 1, 2017.

10) According to your account, NYSOH was unable to confirm the income information listed in your application with state and federal data sources and you were directed to submit proof of your income by April 5, 2017.

11) According to your account, you were disenrolled from the Essential Plan, effective April 30, 2017, because NYSOH had not received the requested income documentation.

12) You submitted an updated application on May 4, 2017 listing the same income information as your previous application, and you were again determined conditionally eligible to enroll in the Essential Plan. You were directed to submit income documentation by August 2, 2017. You subsequently enrolled in an Essential Plan, effective June 1, 2017.

13) As of the date of this decision, no income documentation has been received by NYSOH.

14) You are seeking eligibility for Medicaid, because you testified you cannot afford your Essential Plan's co-pays and premiums.

15) You testified that NYSOH should not base your eligibility on your gross income because you do not actually receive that amount. You further testified that you have personal expenses including rent and bills that should be considered when determining your eligibility for financial assistance.

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

Applicable Law and Regulations

Verification Process

For individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR § 155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR § 155.315(f)).

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 $11,880.00 for a one-person household (81 Federal Register 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)).

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 $11,880.00 for a one-person household (81 Federal Register 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).

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" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Legal Analysis

The first issue under review is whether NYSOH properly determined you were conditionally eligible for the Essential Plan with a $20.00 premium, effective February 1, 2017.

According to your account, you submitted an application for financial assistance with health insurance to NYSOH on January 5, 2017. That application listed your annual household income as $21,840.00, consisting of income earned from your employment at a rate of $12.00 an hour and 35 hours per week. You testified that this amount was correct and the eligibility determination relied upon that information.

During the hearing, although you testified that the income amount in your application was correct, you also testified that NYSOH should use your net income rather than your gross income when calculating your eligibility for financial assistance, because you do not actually receive the gross income amount. Pursuant to the above cited regulations, NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code. 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.

Additionally, you testified that your living expenses such as rent and bills should be considered in the calculation of your eligibility. However, since the Internal

Revenue Service rules do not allow living expenses such as rent, utilities, cable and phone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes.

According to your application, you expect to file your 2017 income taxes with a tax filing status of single and will claim no dependents on your tax return. Therefore, you are in a one-person household for the purposes of calculating your eligibility for financial assistance through NYSOH.

Pursuant to the above cited regulations, the Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income between 138% and 200% of the FPL for the applicable family size. Applicant's with a household income between 150% and 200% of the applicable FPL will be eligible to enroll in the Essential Plan with a $20.00 per month premium contribution. On the date of your application, the relevant FPL was $11,880.00 for a one-person household.

There is no evidence in the record to suggest that you do not meet the non-financial requirements to enroll in the Essential Plan. Accordingly, based on the income information you provided in your January 5, 2017 application, you would be eligible to enroll in the Essential Plan with a $20.00 monthly premium, because an annual household income of $21,840.00 is 183.84% of the applicable FPL.

However, it is noted that, according to your account, NYSOH was unable to verify the income information listed in your January 5, 2017 application.

Pursuant to the regulations, for all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

The January 6, 2017 eligibility determination notice stated that your eligibility to enroll in the Essential Plan with a $20.00 monthly premium was only for a limited time pending receipt of income documentation to confirm the information in your application by April 5, 2017. Since the eligibility determination notice provided you with a reasonable opportunity to submit satisfactory documentary evidence to confirm your eligibility, it is concluded that NYSOH properly determined you conditionally eligible to enroll in the Essential Plan, effective February 1, 2017.

It is noted that according to your account, you were subsequently disenrolled from your Essential Plan, because NYSOH had not received the requested documentation to confirm your eligibility by the deadline provided. You are

currently enrolled in an Essential Plan pursuant to a conditional eligibility pending income documentation. As of the date of this decision, NYSOH has not received any documentation of your income to confirm your eligibility. Therefore, you are reminded that you must submit proof of your income to verify the income information listed in your application to maintain your current coverage.

The second issue under review is whether NYSOH properly determined you were not eligible for Medicaid.

Pursuant to the above regulations, 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 $11,880.00 for a one-person household. Since your January 5, 2017 application indicated your annual household income was $21,840.00, 183.84% of the applicable 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.

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 $1,367.00 per month. Your January 5, 2017 application indicated your monthly income for the month of January 2017, the month in which your application was filed, was $1,680.00. You testified this amount was accurate. Since $1,680.00 is over the allowable monthly income amount of $1,367.00, given the information you provided, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the January 6, 2017 eligibility determination properly stated that, based on the information you provided, you were conditionally eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective February 1, 2017, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The January 6, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: July 18, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

This decision does not affect subsequent eligibility determinations.

You were continually eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective February 1, 2017.

You were ineligible for Medicaid, based on the information in your January 5, 2017 application.

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 January 6, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

This decision does not affect subsequent eligibility determinations.

You were continually eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective February 1, 2017.

You were ineligible for Medicaid, based on the information in your January 5, 2017 application.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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 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.

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.

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).