



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

Notice of Decision

Decision Date: August 3, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016288

[REDACTED]

Dear [REDACTED]

On June 29, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 28, 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: August 3, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000016288



Issues

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

Did NY State of Health properly determine you and your spouse were eligible to enroll in an Essential Plan with a \$20.00 monthly premium?

Did NY State of Health properly determine you and your spouse were not eligible for Medicaid?

Procedural History

On February 15, 2017, NYSOH received two updated applications for financial assistance with health insurance filed on behalf of you and your spouse.

On February 16, 2017, NYSOH issued an eligibility determination notice, based on the last application submitted on February 15, 2017, stating you and your spouse were eligible to enroll in the Essential Plan, with a \$20.00 monthly premium, effective March 1, 2017.

Also on February 16, 2017, NYSOH issued an enrollment notice confirming you and your spouse were enrolled in an Essential Plan with a \$20.00 monthly premium, effective March 1, 2017.

On February 27, 2017, NYSOH received an updated application for financial assistance with health insurance filed on behalf of you and your spouse. That day, a preliminary eligibility determination was prepared stating you and your spouse were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective April 1, 2017.

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Also on February 27, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as you and your spouse were not eligible for an Essential Plan with no monthly premium or Medicaid.

On February 28, 2017, NYSOH issued an eligibility determination notice stating you and your spouse were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective April 1, 2017.

On May 3, 2017, NYSOH issued an eligibility determination notice stating you and your spouse were eligible to enroll in the Essential Plan with no monthly premium, for a limited time, because you and your spouse had been granted Aid to Continue pending the outcome of your appeal. You and your spouse enrolled in an Essential Plan with no monthly premium, effective March 1, 2017.

On June 29, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents.

On July 8, 2017, NYSOH received the requested documentation and it was incorporated into the record as Appellant's Exhibit #1. The record closed thereafter.

Findings of Fact

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

- 1) You and your spouse were enrolled in an Essential Plan with no monthly premium in 2016. The annual household income amount reported on your March 16, 2016 application was \$21,984.00.
- 2) On February 15, 2017, you contacted NYSOH to renew the health coverage for you and your spouse for the 2017 coverage year and two updated applications were submitted on behalf of you and your spouse.
- 3) Both applications increased your attested annual household income to \$41,314.00 consisting of \$22,880.00 you earned annually from your full-time employment and \$18,434.00 your spouse earned annually from her part-time job.
- 4) Both applications indicated you would file your 2017 tax return with a tax filing status of married filing jointly and you would claim two dependents on that tax return.

- 5) You testified that you will claim your parents as your dependents on your 2017 tax return as you did in 2016.
- 6) According to your account, NYSOH determined the eligibility of you and your spouse based on a four-person household.
- 7) Based on the income information in the February 15, 2017 applications, NYSOH determined you and your spouse were eligible to enroll in the Essential Plan with a \$20.00 monthly premium, effective March 1, 2017.
- 8) According to your account, you and your spouse were enrolled in an Essential Plan with a \$20.00 monthly premium on February 15, 2017, with coverage through that plan effective March 1, 2017.
- 9) On February 27, 2017, you contacted NYSOH and an updated application was filed on behalf of you and your spouse reducing your spouse's attested biweekly income from \$709.00 to \$540.00 which reduced your attested annual household income to \$36,920.00. The remaining information remained unchanged from the previous application.
- 10) Based on the updated income information in the February 27, 2017 application, NYSOH still determined you and your spouse eligible to enroll in the Essential Plan with a \$20.00 monthly premium.
- 11) You appealed that determination insofar as you and your spouse were not eligible to enroll in an Essential Plan with no monthly premium or Medicaid.
- 12) You and your spouse were granted Aid to Continue in your Essential Plan with no monthly premium, effective March 1, 2017, pending the outcome of your appeal.
- 13) On July 8, 2017, NYSOH Appeals Unit received the following income documents:
 - a. The following biweekly paystubs for your spouse from [REDACTED]:
 - i. Paystub with check date of February 9, 2017 in the gross amount of \$726.00.
 - ii. Paystub with check date of March 10, 2017 in the gross amount of \$726.00.
 - b. 2016 W-2 forms for your spouse from her former and current employer.

- c. A 2016 W-2 form for you from your current employer indicating wages of \$22,388.50.
 - d. A Form1040A from the joint 2016 tax return of you and your spouse indicating a total adjusted gross income of \$34,014.00 in 2016 and indicating that you claimed your parents as dependents on that return.
 - e. The following biweekly paystubs for you from your full-time employer
 - i. Paystub with check date February 10, 2017 in the gross amount of \$880.00
 - ii. Paystub with check date of February 24, 2017 in the gross amount of \$880.00
- 14) You testified your income is consistent and you earn \$11.00 an hour and work 40 hours per week.
- 15) You testified your spouse's income varies depending on the number of hours she works. You testified you reduced your spouse's attested annual income in the February 27, 2017 application, because she was working fewer hours than previously reported.
- 16) You testified your spouse had a different part-time job in 2016 so your 2016 tax return is not accurate of your household income in 2017.
- 17) Your applications indicate you live in [REDACTED]
- 18) You testified that you and your spouse have various monthly expenses and that you provide financial support for your parents, so you cannot afford to pay for health coverage.

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-

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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 \$24,300.00 for a four-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 2017 FPL, which is \$24,600.00 for a four-person household (82 Fed. Reg. 8831).

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 funds 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 is whether NYSOH properly determined you and your spouse were eligible to enroll in an Essential Plan with a \$20.00 monthly premium.

On February 27, 2017, an updated application was filed on behalf of you and your spouse reducing your spouse’s attested biweekly income from previous applications and, thus, reducing your attested annual household income to \$36,920.00. You testified this information was accurate and the subject eligibility determination relied upon that information.

Although you confirmed the income information listed in the February 27, 2017 application, you testified that you and your spouse have bills and living expenses which render paying for health coverage impossible. 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. Therefore, NYSOH correctly determined the eligibility of you and your spouse based on the annual household income you reported in the February 27, 2017 application of \$36,920.00.

The Essential Plan is 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. You

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testified, and your applications indicate, you and your spouse will file your 2017 tax return with a tax filing status of married filing jointly and you will claim both of your parents as dependents on that tax return. You submitted a form 1040A from the joint tax return of you and your spouse confirming you claimed your parents as dependents in 2016 as well. Thus, for the purposes of determining your eligibility for health insurance through NYSOH, you and your spouse are deemed to be in a four-person household. Your account confirms, NYSOH determined the eligibility of you and your spouse based on a four-person household.

On the date of your February 27, 2017 application, the relevant FPL was \$24,300.00 for a four-person household. Since an annual household income of \$36,920.00 is 151.93% of the 2016 FPL, which is between 138% and 200% of the FPL, NYSOH properly found you and your spouse to be eligible for the Essential Plan.

You testified that you are seeking eligibility for you and your spouse to enroll in an Essential Plan with no monthly premium. However, pursuant to the above cited regulations, applicants are eligible for the Essential Plan with no monthly premium only if their household income is at or below 150% of the FPL. Applicants with a household income greater than 150% of the FPL, but below 200% of the FPL, are eligible to enroll in the Essential Plan with a \$20.00 per month premium contribution.

Since the household income attested to in your February 27, 2017 application of \$36,920.00 is over 150% of the applicable FPL, NYSOH properly determined you and your spouse were eligible to enroll in the Essential Plan with a \$20.00 monthly premium.

The second issue is whether NYSOH properly determined you and your spouse 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 \$24,600.00 for a four-person household. Since the household income amount of \$36,920.00, as attested to in the February 27, 2017 application, is 150.08% of the 2017 FPL, NYSOH properly found you and your spouse 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 two consecutive biweekly paystubs from your full-time employer for the month of February 2017 indicating you earned \$1,760.00 in the month of February 2017. However, you only submitted one biweekly paystub for your spouse for the month of February 2017. The paystub submitted was for a check date of February 9, 2017 in the gross amount of \$726.00. The second paystub you submitted for your spouse was for a check date of March 10, 2017, also in the gross amount of \$726.00. However, since the second paystub was for a paycheck not received in February 2017, it cannot be evidence of the income received by your spouse for the month of February 2017. Accordingly, the documentation submitted is insufficient to establish your monthly household income for the month of February 2017.

The application submitted on February 27, 2017 indicated you had an average monthly income of \$1,906.67 and your spouse had an average monthly income of \$1,170.00 and that the average monthly income of you and your spouse was the same as your income in month of February 2017. It is noted, however, that according to the paystubs submitted, it appears the February 27, 2017 application underreported your spouse's income. Notwithstanding, NYSOH accepted the information in your February 27, 2017 application and based its eligibility determination on that information. Based on the average household monthly income listed in that application of \$3,076.67, you and your spouse do not qualify for Medicaid based on monthly income, because such income is over the allowable monthly income limit of \$2,829.00 (138% of the 2017 FPL).

Since the February 28, 2017 eligibility determination properly stated that, based on the information you provided, you and your spouse were eligible to enroll in the Essential Plan with a \$20.00 monthly premium and, thus, you and your spouse were not eligible for Medicaid, it is correct and is AFFIRMED.

Decision

The February 28, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: August 3, 2017

How this Decision Affects Your Eligibility

You and your spouse remain eligible for the Essential Plan with a \$20.00 monthly premium.

You and your spouse are no longer eligible for the Essential Plan with no monthly premium.

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You and your spouse are not eligible for Medicaid.

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

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- By mail at:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The February 28, 2017 eligibility determination notice is AFFIRMED.

You and your spouse remain eligible for the Essential Plan with a \$20.00 monthly premium.

You and your spouse are no longer eligible for the Essential Plan with no monthly premium.

You and your spouse are not eligible for Medicaid.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

বাংলা (Bengali)

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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।

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye bɛtumi ama wo obi a okyerɛ 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 کرم 1-855-355-5777 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 איר געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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