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

Notice of Decision

Decision Date: October 06, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019693

[redacted]

Dear [redacted]

On September 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 28, 2017 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: October 06, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019693

[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 to enroll in the Essential Plan with a $20.00 premium per month, as of June 1, 2017?
>
> Did NYSOH properly determine that you were ineligible for Medicaid as of June 1, 2017?

Procedural History

On April 27, 2017, you submitted an application for financial assistance through NYSOH.

On April 28, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 premium per month, effective June 1, 2017. The notice also stated that you were ineligible for Medicaid because your household income exceeded the income threshold for this program.

Also on April 28, 2017, NYSOH issued a plan enrollment notice confirming that as of April 27, 2017, you were enrolled in an Essential Plan with enrollment start date of June 1, 2017.

On June 12, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance you were determined eligible to receive.

On September 11, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until September 14, 2017, to allow you to submit: (1) Your bank statement for the period of April 1, 2017 through April 30, 2017; and (2) monthly income statements stating your employers and the gross income issued in each month.

On September 14, 2017, you uploaded documentation to your NYSOH account. You uploaded; (1) A bank account summary for the period of March 8, 2017 through April 7, 2017; (2) Four biweekly paystubs from [redacted] (3) A list of employers and expected income for September 1, 2017 through September 14, 2017 (*see* Documents [redacted] .

That documentation has been made part of the record. The record is now complete and closed.

Findings of Fact

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

1) You testified that you are appealing the amount of financial assistance you were determined eligible to receive.

2) According to your NYSOH account and testimony, you expect to file a 2017 federal income tax return with the tax status of single and do not expect to claim any dependents on that return.

3) According to your April 27, 2017 application, you attested to a 2017 annual household income of $19,000.00.

4) According to your April 27, 2017 application, you did not expect to claim any deductions on your 2017 federal income tax return.

5) According to your April 27, 2017 application, you attested that your average monthly income was the same as your current monthly income.

6) According to your account, you reside in [redacted], New York.

7) You testified that you are a [redacted] and work for several different employers.

8) You further testified that you may work for different employment each month and your earnings are not consistent.

9) You testified that you do not recall if you worked in the month of April 2017, or if you did work, for what employer.

10) On September 14, 2017, you submitted a bank account summary for the period of March 8, 2017 through April 7, 2017 (see Document [redacted].

11) On September 14, 2017, you submitted biweekly paystubs from [redacted] showing you were issued gross income of:

(a) $175.00 on June 6, 2017;
(b) $175.00 on June 20, 2017;
(c) $700.00 on July 5, 2017;
(d) $350.00 on July 18, 2017

(see Documents [redacted]).

12) On September 14, 2017, you submitted a list of employers and expected payment for the month of September 2017. You expect to be issued:

(a) $400.00 from [redacted];
(b) $150.00 from [redacted]

(*see* Document [redacted]).

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” 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.

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).

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)).

On the date of your application, that was the 2017 FPL, which is $12,060.00 for a one-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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan with a $20.00 premium per month, as of April 28, 2017.

On April 27, 2017, you submitted an application for financial assistance through NYSOH. In that application, you attested to an expected annual household income of $19,000.00 and the April 28, 2017, eligibility determination relied upon that information.

You testified that you expect to file a 2017 federal income tax return with the tax status of single and did not expect to claim any dependents on that tax return. Therefore, you are in a one-person household for purposes of this analysis.

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. An individual who has a household income between 151% and 200% of the FPL will have a $20.00 premium contribution

On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $19,000.00 is 159.93% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan, with a monthly premium of $20.00.

The second issue under review is whether NYSOH properly determined you to be 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 $12,060.00 for a one-person household.

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 $1,387.00 per month for a one-person household.

According to your April 27, 2017 application, you attested that your average monthly income was the same as your current monthly income. Based on your attestation, your monthly income was calculated to be $1,583.33 ($19,000.00 / 12 months).

During the hearing, you testified that your earnings were not consistent. Further, you testified that you did not recall if you worked in the month of April 2017, or if you did work, for what employer. The record was left open to allow you to submit your bank account summary for the month of April 2017 to provide evidence of what income was received during that month.

On September 14, 2017, you submitted a bank account summary for the period of March 8, 2017 through April 7, 2017 (Document [redacted]). Since this summary did not show your bank transactions for the entire month of April 2017, it is insufficient evidence to prove your April 2017 income.

Based on the available record, NYSOH properly determined you eligible to enroll in the Essential Plan with a $20.00 monthly premium, and ineligible for Medicaid. Therefore, the April 28, 2017 eligibility determination notice is AFFIRMED.

During the hearing, you testified that you were a [redacted] and worked for multiple employers. The record was left open for you to submit monthly statements, specifying in each month what companies you worked for and the gross income received in that month.

You submitted four biweekly paystubs from [redacted] for the check dates of: June 6, 2017; June 20, 2017; July 5, 2017, and July 18, 2017. Further, you submitted a list of employers and expected payments for September 1, 2017 through September 14, 2017 (see Documents [redacted]).

The documentation submitted does not provide any information regarding your employment or earnings for the period of July 19, 2017, through August 31, 2017. Therefore, the documentation submitted is insufficient to return your case to NYSOH to recalculate your eligibility for financial assistance.

Decision

The April 28, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 06, 2017

How this Decision Affects Your Eligibility

You were properly determined eligible to enroll in an Essential Plan, with a $20.00 monthly premium, effective July 1, 2017.

You were properly determined ineligible for Medicaid as of June 1, 2017.

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 April 28, 2017 eligibility determination notice is AFFIRMED.

You were properly determined eligible to enroll in an Essential Plan, with a $20.00 monthly premium, effective July 1, 2017.

You were properly determined ineligible for Medicaid as of June 1, 2017.

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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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