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

Notice of Decision

Decision Date: November 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020025

[redacted]

[redacted]

On September 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 27, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: November 8, 2017

NY State of Health Account ID: [redacted]
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[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, effective August 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On June 26, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared finding you conditionally eligible to enroll in the Essential Plan, effective August 1, 2017.

Also on June 26, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination insofar as you were not eligible for Medicaid.

On June 27, 2017, NYSOH issued an eligibility determination notice, based on the June 26, 2017 application, stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium for a limited time, effective August 1, 2017. The notice directed you to submit proof of income before September 24, 2017, to confirm your eligibility.

On July 17, 2017, you submitted proof of income, including your spouse's 2017 [redacted] and four of your paystubs dated June 2, 2017

through June 30, 2017 ([redacted]

On July 13, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid in the form of Aid to Continue, effective August 1, 2017.

Also on July 13, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective August 1, 2017.

On September 19, 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) According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.

2) You are seeking Medicaid coverage for yourself.

3) The application that was submitted on June 26, 2017 listed a modified adjusted gross annual income of $28,739.13, consisting of $21,035.13 you earn from your employment and $7,704.00 your spouse receives in [redacted]. This amount included a retirement savings deduction from your income in the amount of $1,003.34, which was calculated by multiplying $38.59 by 26 bi-weekly pay periods in 2017.

4) You testified that you did not get any pay for five bi-weekly pay-period during the summer. Your last paycheck was received on June 30, 2017 and you expect your next paycheck to be received on September 8, 2017. You expect to receive pay in 21 bi-weekly pay periods in 2017.

5) You testified at hearing, and provided documentation to show, that your expected gross annual household income for 2017 is $36,434.40, consisting of $28,718.40 in you earn in an annual salary from your employment and $7,716.00 your spouse receives in [redacted].

6) You further testified, and provided documentation to show, that you will be taking a retirement deduction in the amount of $38.59 bi-weekly. This

totals an expected annual deduction of $810.39 when you multiply your $38.59 retirement deduction by the 21 bi-weekly pay periods you expect in 2017. As such, your expected 2017 modified adjusted gross annual household income is $33,552.01 per year, which is calculated by subtracting your expected retirement deduction of $810.39 from your expected 2017 gross annual household income of $36,434.40 (*id*).

7) You provided documentation that your monthly household income for June 2017 was $5,540.09, consisting of $5,048.55 you received in employment income and $643.00 your spouse received in [redacted] less a[redacted] of $151.46 (*id*).

8) According to your NYSOH account and your testimony, you live in [redacted].

9) You testified that you have rent that you think should be deducted from your household income.

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.

Retirement Savings

"Adjusted gross income" is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, deductions that

are attributable to retirement savings may be deductions from a taxpayer's adjusted gross income (26 USC § 62 (a)(7)).

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 $16,020.00 for a two-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 $16,240.00 for a two-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, effective August 1, 2017.

The application that was submitted on June 26, 2017 listed an annual household income of $28,739.13 and the eligibility determination relied upon that information. During the hearing, you asked that your rent and retirement savings be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent to be deducted from the calculation of your adjusted gross income, it cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. However, retirement savings is an allowable deduction from your adjusted gross income, and although you testified that you only have 21 bi-weekly paychecks per year, NYSOH determined your deduction to be $1,003.34 because in your application you attested that this deduction would take place every two weeks. Therefore, NYSOH properly determined your modified adjusted gross household income to be $28,739.13, based on the gross household income and deductions as you attested to in your application.

According to your NYSOH account and your testimony, you expect to file your 2017 income taxes as married filing jointly and will claim no dependents on that tax return. Therefore, for purposes of these analyses, you are in a two-person household.

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. On the date of your application, the relevant FPL was $16,020.00 for a two-person household. Since an annual household income of $28,739.13 is 179.40% of the 2016 FPL, NYSOH properly found you to be conditionally eligible for the Essential Plan, based on your gross household income and deductions as attested to in your application.

The second issue under review is whether NYSOH properly determined that you were not eligible 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 $20,420.00 for a three-person household. Since $28,739.13 is 177.00% of the 2017 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.

You submitted four paystubs dated June 2, 2017 through June 30, 2017 and your spouse's [redacted] that reflects in June 2017 your household's income was $5,540.09, consisting of $5,048.55 you received in employment income and $643.00 your spouse received in Social Security Benefits less a retirement savings deduction of $151.46.

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 $1,843.00 per month. Since the documentation you provided shows that you received $5,540.09 in modified adjusted gross household income in June 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the June 27, 2017 eligibility determination notice properly stated that, based on the information you provided, you were conditionally eligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

However, since your eligibility was conditional and the record now contains a more accurate representation of your 2017 expected modified adjusted gross annual household income of $33,552.01, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a modified adjusted gross annual household income of $33,552.01 per year, and a household size of two, for an individual residing in [redacted].

Decision

The June 27, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a modified adjusted gross annual household

income of $33,552.01 and a two-person household, for an individual residing in [redacted].

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

Effective Date of this Decision: November 8, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. While your eligibility for financial assistance was based on your attestation of income and correct as of your June 26, 2017 application, your eligibility was conditional, and therefore; your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a modified adjusted gross annual household income of $33,552.01 and a two-person household, for an individual residing in [redacted].

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 June 27, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a modified adjusted gross annual household income of $33,552.01 and a two-person household, for an individual residing in Suffolk County, New York.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

This is not a final determination of your eligibility. While your eligibility for financial assistance was based on your attestation of income and was correct as of your June 26, 2017 application, your eligibility was conditional, therefore; your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a modified adjusted gross annual household income of $33,552.01 and a two-person household, for an individual residing in [redacted].

Legal Authority

We are sending you this notice in accordance with 45 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).

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 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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