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

Notice of Decision

Decision Date: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021339

[redacted]

[redacted]

On October 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 10, 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 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: November 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021339

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine that you were eligible to enroll in the Essential Plan with a $20.00 premium per month, effective September 1, 2017?

Procedural History

On May 20, 2017, NY State of Health (NYSOH) issued an eligibility determination, based on your May 19, 2017 updated application, stating that you were eligible to enroll in the Essential Plan with no monthly payments, effective June 1, 2017. The notice stated that you also qualify for additional benefits through Medicaid.

Also on May 20, 2017, NYSOH issued a plan enrollment notice confirming your May 19, 2017 selection of an Essential Plan with a plan enrollment start date of June 1, 2017.

On August 9, 2017, NYSOH received your updated application for financial assistance.

On August 10, 2017, NYSOH issued an eligibility determination notice stating that you are eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective September 1, 2017. It further stated that you no longer qualify for additional benefits through Medicaid.

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Also on August 10, 2017, NYSOH issued a plan enrollment notice confirming your August 9, 2017 selection of an Essential Plan with a $20.00 monthly premium, with a plan enrollment start date of September 1, 2017.

Also on August 10, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not eligible for the Essential Plan with $0.00 monthly premium.

On September 21, 2017, NYSOH issued eligibility determination and plan enrollment notices stating respectively that you had been granted aid-to-continue until a decision was made on your appeal and you were re-enrolled in Essential Plan 4 with no monthly premium, effective September 1, 2017.

On October 5, 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 until October 20, 2017 to allow you to submit supporting income documentation.

On October 18, 2017, NYSOH received via secure facsimile your 12-page submission consisting of a cover document, a six-page signed statement; a one page letter, dated April 25, 2017, from [redacted] a one page letter, dated August 24, 2017, from [redacted]; a one page letter dated August 22, 2017 from [redacted], a one page letter, dated October 16, 2017, from [redacted] a one page letter, dated October 16, 2017, from [redacted] and a one page letter, dated October 10, 2017, from [redacted]. Collectively these documents were made part of the record as Appellant's Exhibit # 1. The record was closed at that time.

Findings of Fact

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

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

2) You are seeking insurance for yourself.

3) The application that was submitted on August 9, 2017, in which you requested financial assistance, listed annual household income of $21,438.65, consisting of the following income:

   $8,262.50 from [redacted]: $546.15 from [redacted] and $1,450.00 from [redacted]

You also indicated that you were receiving $430.00 a month in unemployment insurance benefits and expected to receive that amount for 26 weeks for a total projected benefit of $11,180.00. You testified that you provided these amounts to the NYSOH customer service representative when completing the August 9, 2017 application and that they were accurate at that time.

4) You testified that your full-time employment ended on March 24, 2017, and that since then you have only worked on temporary or per diem type [redacted] and that you could not possible give a good estimate of what you would earn in 2017.

5) You testified that you expected to receive the full [redacted] $430.00 per week in 2017 and that these [redacted] would end in October 2017.

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

7) On October 18, 2017, you submitted six letters from companies that you have been employed by in 2017. These include the companies that were listed in your August 9, 2017 application and two small additional part time or per diem jobs you have done since then.

8) You testified that you have high living expenses in [redacted] which include rent, food and utilities.

9) You testified that you have a medical condition that requires you to purchase expensive medication on a regular basis and that you cannot afford the co-payments unless you have the Essential Plan with $0.00 monthly premium and additional Medicaid benefits.

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

11) You testified that you are seeking to be found eligible for the Essential Plan with a $0.00 premium per month.

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

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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-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)).

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.

Medical expenses and dental expenses may be itemized on a Form 1040 Schedule A; however, these expenses are not used to compute adjusted gross income (26 USC § 213(a); Internal Revenue Service (IRS) Publication 502 (2016)).

Legal Analysis

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

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2017 income taxes as single and will claim no dependents.

During the August 9, 2017 application process with a NYSOH customer service representative, you provided the income amounts that you had received from various employers to that date which totaled $10,258.65 ($8,262.50 + $546.15 + $1,450.00). The record reflects and you testified that you were also receiving $430.00 a week in [redacted] and that you expected to receive the [redacted] in 2017 for total benefits of $11,180.00. Based on the information you provided, on August 9, 2017, NYSOH calculated your expected gross annual household income for 2017 at $21,438.65, and the eligibility determination relied on that information.

During the hearing, you asked that your high expenses of living in [redacted] such as rent, utilities food and your prescription medication, be considered when determining your household's eligibility for financial assistance. You did not provide any amounts for those expenses.

However, the Internal Revenue Service rules do not allow living expenses such as rent, utilities, food or medication to be deducted from the calculation of your adjusted gross income. Furthermore, although medical and dental expenses may be itemized on your tax return, the Internal Revenue Service rules do not allow medical expenses to be deducted from the calculation of your adjusted gross income. Therefore, these expenses cannot be deducted when NYSOH computes your household's modified adjusted gross income for the purpose of

determining your eligibility for financial assistance with health insurance. Therefore, NYSOH correctly determined your household income to be $21,438.65.

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. Applicants with a household income that is at or below 150% of the FPL have a $0.00 premium contribution and applicants with a household income that is greater than 150% of the FPL or below 200% of the FPL have a $20.00 per month premium contribution.

On the date of your August 9, 2017 application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $21,438.65 is 180.46% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan with a $20.00 monthly premium.

Since the August 10, 2017 eligibility determination notice properly stated that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective September 1, 2017, it is correct and is AFFIRMED.

Following the hearing, you submitted additional income documentation, however, this documentation does not show any significant change in household income from the documentation you previously submitted such that no further action is required by NYSOH.

Decision

The August 10, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 14, 2017

How this Decision Affects Your Eligibility

You remain eligible to enroll in the Essential Plan with a $20.00 monthly premium.

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.

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).

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

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Summary

The August 10, 2017 eligibility determination notice is AFFIRMED.

You remain eligible to enroll in the Essential Plan with a $20.00 monthly premium.

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:

[redacted]

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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)

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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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई 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)

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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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