STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: December 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022120

[redacted]

Dear [redacted],

On November 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 5, 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
  PO 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(b).

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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Decision

Decision Date: December 20, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022120

[redacted]

Issues

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

> Did NYSOH properly determine you were eligible for the Essential Plan with a $20.00 monthly premium, effective October 1, 2017?
>
> Did NYSOH properly determine you were not eligible for Medicaid?

Procedural History

On September 4, 2017, NYSOH received your updated application for financial assistance with your health insurance. That day, a preliminary eligibility determination was prepared, stating you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective October 1, 2017.

Also on September 4, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as you were not eligible for Medicaid.

On September 5, 2017, NYSOH issued a notice of eligibility determination, based on the September 4, 2017 application, stating you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective October 1, 2017. That notice also stated that you were not eligible for Medicaid, because your household income was over the allowable income limit for that program.

On September 9, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, for a limited time, effective October 1, 2017, until

a decision was made on your appeal. You subsequently reenrolled into a Medicaid Managed Care plan, effective October 1, 2017.

On November 13, 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 November 13, 2017, the requested documentation was uploaded to your NYSOH account. That documentation was incorporated into the record as Appellant's Exhibit #1 and the record closed thereafter.

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 married filing jointly. You will claim two dependents on that tax return.

2) You testified this appeal involves your coverage only.

3) You submitted an updated application on September 4, 2017 listing your annual household income as $38,000.00, consisting solely of income earned by your spouse. You testified that income amount was correct.

4) NYSOH calculated your average monthly household income as $3,166.67. You testified that amount was correct.

5) Based on the information in the September 4, 2017 application, NYSOH determined you eligible for the Essential Plan with a $20.00 monthly premium, effective October 1, 2017.

6) You appealed that determination insofar as you were not eligible for Medicaid.

7) You testified that your spouse pays $241.21 weekly in child support which should be deducted from the household income calculation when determining your eligibility for financial assistance through NYSOH.

8) Your application indicates you will not take any deductions on your 2017 tax return.

9) You testified that you are in school full time and you will take a deduction for tuition in fees, but you were not sure of the exact amount. You testified that you took a tuition and fees deduction in 2016, but it would be less than the amount in 2017, because you were attending a different school.

10) You were directed to submit a copy of your 2016 tax return to show the amount of the deduction taken for tuition and fees. As of the date of this decision, no such documentation has been received and there have been no updates made to your NYSOH account indicating that you will be taking a deduction in 2017.

11) You testified that your spouse makes weekly pre-tax 401K contributions and medical insurance premium payments. You were directed to submit copies of your spouse's most current paystubs to show the amount of his weekly pre-tax deductions.

12) On November 13, 2017, NYSOH received four weekly paystubs containing the following information:

    a. Pay date of October 13, 2017 with gross taxable wages, after pre-tax 401K and insurance contributions deducted, in the amount of $712.99.

    b. Pay date of October 20, 2017 with gross taxable wages, after pre-tax 401K and insurance contributions deducted, in the amount of $810.33.

    c. Pay date of October 27, 2017 with gross taxable wages, after pre-tax 401K and insurance contributions deducted, in the amount of $917.35.

    d. Pay date of November 3, 2017, for pay period ending October 28, 2017, with gross taxable wages, after pre-tax 401K and insurance contributions deducted, in the amount of $882.76 and year to date taxable income of $35,344.78.

13) Your application indicates you live in Orange County.

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-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 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, *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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 Federal Register 8831, 8832).

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 (*id*.).

Child Support

Generally, payments made for the support of children are not included in the gross income of the parent receiving the payment. Conversely, payments made for the support of children are not an allowable deduction in computing adjusted gross income (26 USC § 71(c)(1)).

Legal Analysis

The first issue is whether NYSOH properly determined you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective October 1, 2017.

The application submitted on September 4, 2017 listed an annual household income of $38,000.00 and the eligibility determination relied upon that information.

It is noted that although your application indicates you will not take any deductions on your 2017 tax return, you testified you will take a deduction for tuition and fees, but you were unsure of the exact amount. You further testified that you took this deduction in 2016, but you failed to submit any corroborating documentation despite being directed to do so. Thus, there is insufficient evidence that you will be taking a deduction on your 2017 tax return. In the event you decide to take any such deduction, you should update your NYSOH account with that information.

During the hearing, you testified that your spouse pays $241.21 per week in child support which should be deducted from the household income calculation when

determining your eligibility for financial assistance through NYSOH. However, in accordance with the above cited regulations, the Internal Revenue Service rules do not allow payments made for the support of children to be deducted in computing adjusted gross income. Thus, such payments cannot be deducted when the NYSOH computes your modified adjusted gross income for eligibility purposes. Therefore, NYSOH correctly determined your household income to be $38,000.00 based on the information provided in your application.

The evidence establishes that you are in a four-person household, because you will file your 2017 income taxes as married filing jointly and will claim two dependents on that tax return.

The September 5, 2017 eligibility determination found you eligible for the Essential Plan with a $20.00 monthly premium, effective October 1, 2017. You appealed that determination insofar as you were not eligible for Medicaid.

Pursuant to the above regulations, 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 $24,300.00 for a four-person household. Since an annual household income of $38,000.00 is 156.38% of the 2016 FPL, NYSOH properly found you eligible for the Essential Plan. Additionally, since the household income provided was between 150% and 200% of the FPL, you were properly assessed a $20.00 per month premium contribution.

The second issue is whether NYSOH properly determined you 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 $38,000.00 is 154.47% of the 2017 FPL, NYSOH properly found you 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.

According to your account, NYSOH calculated your average monthly household income as $3,166.67 based on the income information you provided in your September 4, 2017 application. You testified that amount was correct.

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 $2,829.00.00 per month. Since the information you provided establishes that your average monthly household income was $3,166.67, you would not qualify for Medicaid based on monthly income as of the date of your application.

Because the September 5, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan with a $20.00 monthly premium, and ineligible for Medicaid, it is correct and is AFFIRMED.

It is noted that following the hearing, you submitted updated income documentation for your spouse showing that he makes weekly pre-tax 401K contributions as well as pre-tax payments for health, dental, and vision insurance premiums. The most recent paystub submitted for the pay period ending October 28, 2017 shows a gross taxable year to date income, after accounting for pre-tax deductions, in the amount of $35,344.78. Based on that year to date amount, it is concluded that your spouse's gross weekly taxable earnings for the first 43 weeks of 2017 are $821.97. This amounts to an annual taxable income amount of $42,742.52.

Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance going forward, based on an annual income of $42,742.52 and a household size of four, as established by the now developed record.

Decision

The September 5, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance going forward, based on an annual income of $42,742.52 and a household size of four.

Effective Date of this Decision: December 20, 2017

How this Decision Affects Your Eligibility

You were eligible for the Essential Plan with a $20.00 monthly premium, effective October 1, 2017.

You are ineligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your eligibility going forward based on the updated income documentation submitted.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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 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).

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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The September 5, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance going forward, based on an annual income of $42,742.52 and a household size of four.

You were eligible for the Essential Plan with a $20.00 monthly premium, effective October 1, 2017.

You are ineligible 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:

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).