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

Notice of Decision

Decision Date: December 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022225

[redacted]

[redacted]

On November 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 6, 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.

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P.O. Box 11729
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Decision

Decision Date: December 11, 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 to enroll in the Essential Plan, effective October 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for Medicaid, as of September 5, 2017?

Procedural History

On August 3, 2017, NYSOH issued a renewal notice, stating that you were now qualified for coverage under the Essential Plan with a $20.00 monthly premium, effective October 1, 2017. The notice also stated that if you believed the information in the renewal notice was incorrect, or if anything had changed in your life that would affect your eligibility for coverage and financial assistance, you should update your NYSOH account between August 16, 2017 and September 15, 2017.

On August 17, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in your Medicaid Managed Care (MMC) plan was ending as of September 30, 2017 because you were no longer eligible to remain enrolled in that plan.

Also on August 17, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Emblem Health Essential Plan 1, with a $20.00 monthly premium, beginning October 1, 2017.

On August 21, 2017, you updated your NYSOH account.

On August 22, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to provide documentation of your household income by September 5, 2017.

Also on August 22, 2017, NYSOH issued a disenrollment notice, stating that your enrollment in an Essential Plan would end, effective October 1, 2017, because you were no longer eligible to enroll in the Essential Plan.

On August 24, 2017, documentation was uploaded to your NYSOH account.

On August 27, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application. The notice directed you to submit documentation of your income by September 20, 2017.

On September 4, 2017, documentation was uploaded to your NYSOH account.

On September 5, 2017, NYSOH determined your eligibility.

On September 6, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective October 1, 2017.

On September 7, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination, insofar as you were not eligible for Medicaid. You also requested Aid to Continue, pending the outcome of your appeal.

On September 13, 2017, NYSOH issued a notice of eligibility determination, stating that you were eligible for Medicaid for a limited time, effective October 1, 2017. This was because your request for Aid to Continue was granted, pending the outcome of your appeal.

Also on September 13, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an MMC plan, beginning October 1, 2017. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On November 21, 2017, you appeared at a telephone hearing, along with [redacted], who acted as your Authorized Representative (AR), with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open through December 6, 2017 to allow you time to submit supporting documentation.

On November 22, 2017 and December 4, 2017, documentation was uploaded to your NYSOH account. The record is now closed.

Findings of Fact

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

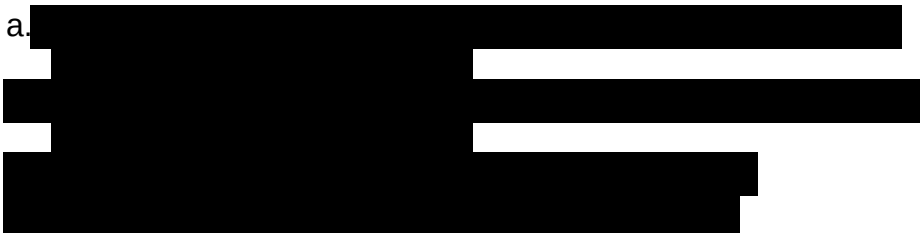
1) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You testified that you are looking to be eligible for Medicaid, instead of the Essential Plan.

3) Your AR testified that you have [redacted] that require costly medications, and you cannot afford to maintain your health with the copays and other costs of the Essential Plan.

4) On September 4, 2017, you uploaded documentation to your NYSOH account for the following dates and gross taxable earnings:

a. [redacted]



5) NYSOH calculated your annual expected income to be $19,053.93, after you uploaded the above documentation.

6) You testified that you do not believe this income figure to be accurate.

7) You testified that you earn $11.45 an hour, and work approximately 24 hours per week. You testified that you believe you will earn less than $17,000.00 in 2017.

8) You testified that you are paid weekly.

9) You testified that you worked one day this year [redacted] as reflected by your August 21, 2017 application, which indicates that you earned $300.00 in that employment.

10) Your application does not indicate that you will be taking any deductions on your 2017 tax return. However, at the hearing, you testified that you did

pay tuition for classes you are taking, so you may have a deduction for tuition and fees.

11) Your application indicates that you reside in [redacted]

12) Your AR testified that one of your biggest concerns is that you will be unable to afford your care if you are required to enroll in the Essential Plan, and that this could cause you to become truly disabled and unable to work.

13) After the hearing, you uploaded documentation to your NYSOH account consisting of the following:

[redacted]

d. A copy of your 11/17/2017 paystub showing gross taxable earnings of $274.40, and [redacted]

[redacted] A copy of a two-page printout from [redacted] showing a payment of $1,918.85 made on July 14, 2017, and a breakdown showing that this payment was for [redacted], consolidated fees, technology fees, student activity fees, and [redacted]

f. A second copy of your 11/17/2017 paystub (Document [redacted]

g. A copy of your 11/24/2017 paystub showing gross taxable earnings of $311.50, and year-to-date earnings of $16,070.10 (Document [redacted].

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 2015 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/downloads/ny-blueprint.pdf).

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 $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).

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" is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, tuition and fees for a dependent's higher education paid by the tax payer to a qualified educational institution can be deducted from adjusted gross income in an amount up to $4,000.00, provided the tax payer's yearly income does not exceed $80,000.00 for a single individual or $160,000.00 if married filing jointly. This deduction was renewed by Congress in December 2014 and made retroactive to the 2014 tax year and extended to December 31, 2017 (26 USC § 222(e); *see* IRS Publication 970).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective October 1, 2017.

On September 4, 2017, you uploaded income documentation to your NYSOH account, and NYSOH used that documentation as the basis of its determination that your expected annual income for 2017 was $19,053.93.

You are in a one-person household. You expect to file your 2017 income taxes as single, and will claim no dependents on that tax return.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $19,053.93 is 160.39% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan, based on its calculation of your expected annual income.

However, after the hearing, you submitted income documentation showing that your year-to-date gross income, as of November 24, 2017, was $16,070.10. You testified that you are paid weekly. Your November 24, 2017 paystub represented 47 weeks' worth of pay. Therefore, your average weekly salary is $341.92 ($16,070.10 divided by 47 weeks). Since there are five weeks left in the year, you

will earn approximately $1,709.60 in that time ($341.92 times five weeks). Therefore, your expected annual income from your employment is $17,779.70, plus the $300.00 you earned from the [redacted], for a total expected income of $18,079.70 for 2017.

You also submitted documentation that shows that you have paid $1,918.85 in tuition and fees toward an undergraduate degree in 2017. NYSOH bases its eligibility determinations on an individual's "MAGI," which is an individual's adjusted gross income minus certain specific deductions. One of these deductions is tuition and fees paid by a taxpayer to a qualified higher educational institution. A taxpayer can deduct an amount of up to $4,000.00 on their taxes, as long as their yearly income does not exceed $80,000.00.

The documentation submitted that shows that you have paid $1,918.85 in tuition and fees toward an undergraduate degree in 2017 from [redacted] Since your expected annual income does not exceed $80,000.00, and since the fees you paid appear to be allowable deductions, your modified adjusted gross income for 2017 is $16,160.85 ($18,079.70 minus $1,918.85).

The second issue is under review is whether NYSOH properly determined that 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 $12,060.00 for a one-person household. Since $19,053.93 is 157.99% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the income figure NYSOH calculated from your income documentation.

The September 6, 2017 eligibility determination is AFFIRMED, as it was based on information available to NYSOH at that time.

However, since the record now contains a more accurate representation of what your expected annual household income is, your case is RETURNED to NYSOH to redetermine your eligibility for coverage, effective October 1, 2017, based on a one-person household, residing in [redacted] with an annual household income of $16,160.85

NYSOH is directed to notify you of your new eligibility in writing.

Decision

The September 6, 2017 eligibility determination notice is AFFIRMED, insofar as it was based on information available to NYSOH at the time.

Your case is RETURNED to NYSOH to redetermine your eligibility for coverage, effective October 1, 2017, based on a one-person household, residing in [redacted] an annual household income of $16,160.85.

NYSOH is directed to promptly notify you in writing of your new eligibility.

Effective Date of this Decision: December 11, 2017

How this Decision Affects Your Eligibility

NYSOH properly determined you eligible for the Essential Plan, based on the information available as of September 5, 2017.

However, based on the documentation provided after the hearing, your case is being sent back to NYSOH to redetermine your eligibility for coverage as of October 1, 2017.

NYSOH will send you a notice to inform you of your new eligibility.

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:

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).

- 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 September 6, 2017 eligibility determination notice is AFFIRMED, insofar as it was based on information available to NYSOH at the time.

Your case is RETURNED to NYSOH to redetermine your eligibility for coverage, effective October 1, 2017, based on a one-person household, residing in Queens County with an annual household income of $16,160.85.

NYSOH is directed to promptly notify you in writing of your new eligibility.

NYSOH properly determined you eligible for the Essential Plan, based on the information available as of September 5, 2017.

However, based on the documentation provided after the hearing, your case is being sent back to NYSOH to redetermine your eligibility for coverage as of October 1, 2017.

NYSOH will send you a notice to inform you of your new eligibility.

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।

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).