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

Notice of Decision

Decision Date: February 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024055

[redacted]

[redacted]

On January 25, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: February 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024055

[redacted]

Issues

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

> Did NY State of Health properly determine that you were eligible for the Essential Plan for a limited time, effective December 1, 2017?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On October 26, 2017, you submitted an application for financial assistance.

On October 27, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan for a limited time, effective December 1, 2017. That notice also stated that you were not eligible for Medicaid because your income was over the allowable income limit for that program. This notice directed you to submit proof of your household income by January 24, 2018 in order to confirm your eligibility for financial assistance.

On November 6, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not found eligible for Medicaid.

On January 25, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open for fourteen days, to allow you to submit supporting documents.

On January 29, 2018, NYSOH redetermined your eligibility for financial assistance.

On January 30, 2017, NYSOH issued a notice of eligibility redetermination stating that you were eligible for up to $355.00 per month in advance payments of the premium tax credit, effective March 1, 2018. This was because state and federal data sources showed that your household income was between $16,643.00 and $48,240.00.

On February 8, 2018, the Appeals Unit received via fax seven of your paystubs. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. 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 not claim any dependents on that tax return.

2) You are seeking insurance for yourself

3) The application that was submitted on October 26, 2017 listed annual household income of $20,800.00, consisting of wages you earn from your employment. You testified that you are not sure if this amount is correct as your pay varies from week to week.

4) You testified that you worked for the same employer throughout 2017 and only had one employer in 2017. You testified that you continue to work for the same employer.

5) You testified that you are paid on a weekly basis and that your pay is based on commission only.

6) Your application states that you will not be taking any deductions on your 2017 tax return. You testified that you are currently subject to a wage garnishment for [redacted] and the [redacted], as well as for [redacted] debit.

7) You testified that you have a serious medical condition for which you pay several thousand dollars per year, as you have been unable to find a specialist who accepts Medicaid. You testified that you have other medical conditions, [redacted] of which is covered, however you went

on to testify that the copays required under the Essential Plan would be unaffordable for you.

8) Your application states, and you confirmed, that you live in Suffolk County.

9) On February 8, 2018, you faxed seven paystubs to the Appeals Unit; the first is for pay date October 6, 2017 for a gross pay amount of $584.00; the second is for pay date October 13, 2017 for a gross pay amount of $400.00; the third is for pay date October 20, 2017 for a gross pay amount of $809.00; the fourth is for pay date October 27, 2017 for a gross pay amount of $690.00; the fifth is for pay date December 29, 2017 for a gross pay amount of $240.00 and a gross year to date amount of $26,485.00; the sixth is for pay date January 5, 2018 for a gross pay amount of $261.00 and a year to date gross amount of $261.00; the seventh is for pay date February 2, 2018 for a gross pay amount of $943.00 and a gross year to date amount of $2,839.00.

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 $11,880.00 for a one-person household (81 Fed. Reg. 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 $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" 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)).

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)).

State, local, and foreign real property taxes, state and local personal property taxes, state and local, and foreign, income and excess profit taxes may be itemized on Form 1040 Schedule A; however, these expenses are not used to compute adjusted gross income (26 USC §164(a)). No deduction may be claimed for Federal income taxes (26 USC §275(a)(1)).

Legal Analysis

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

The application that was submitted on October 26, 2017 listed an annual household income of $20,800.00 and the eligibility determination relied upon that information.

During the hearing, you testified that you did not know if the amount you provided in your application was correct. However, you asked that your current expenses, which include medical expenses and wage garnishments for [redacted], as well as [redacted], be considered when calculating your annual household income.

Although payment of certain taxes may be claimed as deductions on your tax return as well as certain medical expenses, since the Internal Revenue Service rules do not permit payment of taxes, medical expenses, or credit card payments to be deducted from the calculation of your adjusted gross income, they cannot be deducted when NYSOH computes your modified adjusted gross income for the purpose of determining your eligibility for financial assistance. Therefore, NYSOH correctly determined your household income to be $20,800.00 based on the information in your October 26, 2017 application.

You expect to file your 2017 income taxes as single and will not claim any dependents on that tax return. Therefore, you are in a one-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 $11,880.00 for a one-person household. Since an annual household income of $20,800.00 is 175.08% of the

2016 FPL, NYSOH properly found you to be eligible for the Essential Plan for a limited time.

The second issue 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 $20,800.00 is 172.47% 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 paystubs that shows in October 2017 you received $2,483.00.

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. Since the documentation you provided shows that you earned $2,483.00 in October 2017 you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

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

Following the hearing, you submitted documentation that your annual expected income is currently $26,485.00.

Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a household of one residing in Suffolk County with an annual expected income of $26,485.00.

Decision

The October 27, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a household of one residing in Suffolk County with an annual expected income of $26,485.00.

Effective Date of this Decision: February 14, 2018

How this Decision Affects Your Eligibility

NYSOH properly found you eligible for the Essential Plan for a limited time, effective December 1, 2017.

This decision does not affect any subsequent eligibility determinations.

Your case is being sent back to NYSOH to redetermine your eligibility based on income documentation you submitted following your hearing.

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 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 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 October 27, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly found you eligible for the Essential Plan for a limited time, effective December 1, 2017.

This decision does not affect any subsequent eligibility determinations.

Your case is being sent back to NYSOH to redetermine your eligibility based on income documentation you submitted following your hearing.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a household of one residing in Suffolk County with an annual expected income of $26,485.00.

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 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.

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).