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

Notice of Decision

Decision Date: February 1, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024861

[redacted]

[redacted],

On January 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 28, 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 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
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Decision

Decision Date: February 1, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024861

[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 with a $20.00 premium per month, as of November 28, 2017?
>
> Did NYSOH properly determine that you were ineligible for Medicaid as of November 28, 2017?

Procedural History

On November 27, 2017, an application for financial assistance was submitted through NYSOH. Based on that application, NYSOH rendered a preliminary eligibility determination finding you eligible to enroll in the Essential Plan with a $20.00 premium for a limited time, effective as of January 1, 2018.

Also on November 27, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as you were not eligible for Medicaid.

On November 28, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 premium per month for a limited time, effective as of January 1, 2018. The notice directed you to provide proof of your income by February 25, 2018, to confirm your eligibility. Further, the notice stated that you were not eligible for Medicaid because your household income was over the allowable income limit for that program.

On January 8, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until January 22, 2018, to allow you to submit to NYSOH's Appeals Unit the following documents: (1) A separation letter from your former employer; and (2) your last two biweekly paystubs from your former employer.

On January 9, 2018, you uploaded additional documentation to your NYSOH account [redacted]

On January 10, 2017, your NYSOH account was systematically updated.

On January 11, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid, effective January 1, 2018.

Also on January 11, 2018, NYSOH issued a plan enrollment notice confirming that as of January 10, 2018, you were enrolled in an Medicaid Managed Care (MMC) plan with an enrollment start date of January 1, 2018.

On January 21, 2018, you uploaded additional documentation to your NYSOH account [redacted]. That documentation has been incorporated into the record. The record is now complete and closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for health insurance for yourself.

2) You testified that you are seeking to be found eligible for Medicaid.

3) According to your November 27, 2017 application, you testified that you expect to file a 2018 federal income tax return with the tax status of married filing jointly and do not expect to claim any dependents on that tax return.

4) According to your November 27, 2017 application, you attested to an annual income of $18,520.00, and an annual income of $12,900.00 for your spouse. Based on that attestation, your annual household income was computed to be $31,420.00.

5) According to your November 27, 2017 application, you attested that your average monthly income was the same as your current monthly income.

6) According to your NYSOH account, you do not expect to claim any deductions on your federal income tax return.

7) You testified that your employment at the [redacted] was a seasonal position and you are no longer employed.

8) On January 9, 2018, you uploaded a memorandum from the co-director of [redacted]. The letter states that your last day of employment was on December 29, 2017 [redacted]

9) On January 21, 2018, you uploaded two paystubs from your employment with [redacted] On January 4, 2018, you were issued $1,007.78, and on January 18, 2018, you were issued $462.83 ([redacted]

10) You testified that you have not applied for unemployment insurance benefits; however, you plan to apply in the next seven to ten days.

11) You testified that your spouse's only source of income is Social Security Benefits, and he was receiving $1,100.00 monthly as of January 1, 2018.

12) According to your NYSOH account, you reside in [redacted], New York.

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)).

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 $16,240.00 for a two-person household (82 Federal Register 8831).

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).

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)).

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, for a $20.00 premium per month, as of November 28, 2017.

On November 27, 2017, you submitted an application for financial assistance through NYSOH. In that application, you attested to an expected annual household income of $31,420.00 and the November 28, 2017 eligibility determination relied upon that information.

According to your November 17, 2017 application, you expected to file a 2018 federal income tax return with the tax status of married filing jointly and did not expect to claim any dependents on that tax return. Therefore, 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. An individual who has a household income below 150% of the FPL will have a $0.00 premium contribution

On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since an annual household income of $31,420.00 is 193.47% of the 2017 FPL, NYSOH properly found you to be eligible for the Essential Plan, with a monthly premium of $20.00.

The second issue under review is whether NYSOH properly determined you to be 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 $16,240.00 for a two-person household.

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 $1,868.00 per month for a two-person household.

Your November 27, 2017 application reflected that you attested that your average monthly income was the same are your currently monthly income. Therefore, your monthly income was computed to be ($31,420.00 / 12 months) $2,618.33. Therefore, your monthly income of $2,618.33 exceeded the maximum allowable monthly income amount of $1,868, and you did not qualify for Medicaid at that time.

Therefore, the November 28, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible to enroll in the Essential Plan, with a $20.00 monthly premium, and ineligible for Medicaid, and is AFFIRMED.

During the hearing, you testified that your employment at [redacted] was a seasonal position and are no longer employed. Based on the change in your employment status, the Hearing Officer directed you to submit a letter from your former employer and your last two biweekly paystubs.

On January 9, 2018, you uploaded a memorandum from the co-director of [redacted] stating that your last day of employment was on December 29, 2017 [redacted]. On January 12, 2018, you uploaded your January 4, 2018, and January 18, 2018. paystubs from your employment with [redacted] (*see* Documents [redacted]

Based on the submission of this documentation, NYSOH determined you eligible for Medicaid on January 10, 2018. Therefore, your case will not be returned to NYSOH to recalculate your eligibility for financial assistance based on the documentation submitted to NYSOH's Appeals Unit.

Decision

The November 28, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 1, 2018

How this Decision Affects Your Eligibility

NYSOH properly determined you to be eligible to enroll in the Essential Plan with a $20.00 monthly premium as of November 28, 2017.

NYSOH properly determined you to be ineligible for Medicaid as of November 28, 2018.

NYSOH redetermined you eligible for Medicaid on January 10, 2018. Therefore, your case will not be returned to NYSOH to recalculate your eligibility for financial assistance based on the documentation submitted to NYSOH's Appeals Unit.

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 November 28, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined you to be eligible to enroll in the Essential Plan with a $20.00 monthly premium as of November 28, 2017.

NYSOH properly determined you to be ineligible for Medicaid as of November 28, 2018.

NYSOH redetermined you eligible for Medicaid on January 10, 2018. Therefore, your case will not be returned to NYSOH to recalculate your eligibility for financial assistance based on the documentation submitted to NYSOH's Appeals Unit.

Legal Authority

We are issuing this determination 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)

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).

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 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)

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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.

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).