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

Notice of Decision

Decision Date: March 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025493

[redacted]

Dear [redacted]

On February 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 24, 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: March 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025493

[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 with a $20.00 per month premium as of December 1, 2017?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

According to your NY State of Health (NYSOH) account, you updated your application on October 20, 2017, and were placed in pending Medicaid status until you provided proof of income to confirm your eligibility. Pursuant to NYSOH's request for proof of income, you submitted two consecutive bi-weekly paystubs dated September 29, 2017 and October 13, 2017 (*see* Document [redacted] These documents were validated by NYSOH on October 23, 2017.

On October 24, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium for a limited time, effective December 1, 2017. The notice stated that you were not eligible for Medicaid because your income of $19,604.00 was over the allowable income limit for that program.

On December 7, 2017, you spoke to NYSOH's Account Review Unit and appealed the amount of your financial assistance.

On January 23, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with no monthly premium, effective November 1, 2017. The notice stated that you have been granted Aid to Continue until a decision is made on your appeal.

Also on January 23, 2018, a plan enrollment notice was issued stating that you were enrolled in an Essential Plan with no monthly premium, effective November 1, 2017.

On February 12, 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 to February 27, 2018, to allow you to submit supporting documents.

On February 22, 2018, you submitted a copy of your Unemployment Official Record of Benefit Payment History. This document was made part of the record as "Appellant's Exhibit A." No further documentation was received as of February 27, 2018, and the record was closed that day.

Findings of Fact

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

1) According to your NYSOH account and testimony, you expect to file your 2017 taxes with a tax filing status of single and will claim no dependents on your tax return.

2) You are seeking Medicaid or the Essential Plan with no premium for yourself.

3) The application that was submitted on October 22, 2017, listed annual household income of $19,604.00 in gross earnings from your employment. You testified that you received about $23,000.00 in gross income in 2017.

4) You testified that your income for the month of October 2017, was $1,989.00, consisting of $624.00 in earnings you received on October 13, 2017 and $1,365.00 in earnings you received on October 27, 2017.

5) You testified that you expect your income for 2018 to decrease because you stopped working for your employer as of January [redacted] 2018.

6) You testified that your last paystub was dated January 21, 2018.

7) You testified that your employer will not provide a letter of separation showing your end date from your employment.

8) You testified you are now only receiving unemployment in an amount of $195.00 per week.

9) On February 22, 2018, you submitted a copy of your Unemployment Official Record of Benefit Payment History. This document shows that from week ending October 15, 2017 through week ending January 14, 2017, you received $48.75 per week (1 effective day) in unemployment benefits and between January 21, 2018 and February 11, 2018, you were receiving an unemployment benefit of $195.00 per week (4 effective days) (*see* Appellant's Exhibit A, [redacted]).

10) You testified, in the present tense, that you are a [redacted] and have a monthly transit deduction of $121.00, which you must pay to get to work. You further testified that you have a [redacted] expense in the amount of $26.00 bi-weekly, a [redacted] renewal fee, and rent that you would like considered when making your eligibility determination.

11) You failed to submit proof of your deductions.

12) According to your NYSOH account and testimony, you live 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

Pre-Tax Transit Deduction

"Gross income" is all the income of the taxpayer from whatever source derived, including but not limited to compensation for services, gross income derived from business, interest, rents, dividends, pensions, and alimony, unless excluded by law (26 USC § 61). Subject to some limitations, certain fringe benefit deductions from an individual's income that are attributable to a Pre-Tax Transit could be excluded from a taxpayer's gross income (26 USC § 132 (5).

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, dry-cleaning, license renewal fees and utilities are not an allowable deduction in computing adjusted gross income.

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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium as of December 1, 2017.

The application that was submitted on October 22, 2017, listed an annual household income of $19,604.00 and the eligibility determination relied upon that information. During the hearing, you testified that the amount you provided in your application was correct. However, you further testified that you are a [redacted] and have a monthly transit deduction of $121.00 which you must pay to get to work. You further testified that you have a [redacted] expense in the amount of $26.00 bi-weekly, a [redacted] renewal fee, and rent that you would like considered when making your eligibility determination.

Since the Internal Revenue Service rules do not allow living expenses such as rent, dry-cleaning and license renewal fees to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for eligibility determination purposes. Although certain unreimbursed employee expenses, such as transit expenses that are taken out of an employee's pay as pre-tax contributions, may be deductible from income, you did not provide any proof of this deduction. Therefore, NYSOH correctly determined your household income to be $19,604.00.

According to your NYSOH account and testimony, you expect to file your 2017 income taxes as single and will claim no dependents on that tax return. Therefore, for purposes of these analyses, you are in a one-person household. The Essential Plan is provided through NYSOH to individuals who meet the nonfinancial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% of the FPL for the applicable family size. The applicable FPL at the time of your October 22, 2017 application was $11,880.00 for a one-person household.

Since a household income of $19,604.00 is 165.02% of the applicable FPL for a one-person household, NYSOH properly found you to be eligible for the Essential Plan as of December 1, 2017. In addition, because your income is between 150% and 200% of the applicable FPL, NYSOH properly found your Essential Plan premium contribution to be $20.00, based on the income information you provided.

The second issue under review is whether NYSOH properly determined that you were not eligible 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 $19,604.00 is 162.55% 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 testified that your income for the month of October 2017 was $1,989.00, consisting of $624.00 you received on October 13, 2017 and $1,365.00 you received on October 27, 2017.

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 $1,367.00 per month. Since you testified that you earned $1,989.00 in October 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the October 23, 2017 eligibility determination notice 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, it is correct and is AFFIRMED.

Finally, it is noted that you testified that you stopped working for your employer as of January [redacted] 2018, received your last paycheck on January 21, 2018, and are now only receiving unemployment in an amount of $195.00 per week. You also submitted a copy of your Unemployment Official Record of Benefit Payment History showing that, as of January 21, 2018, you began receiving an increase from $48.75 for 1 effective day per week to $195.00 per week for 4 effective days per week in unemployment (*see* Appellant's Exhibit A, [redacted] Despite your contradictory testimony as to your current employment status, your Unemployment Official Record of Benefit Payment History supports your testimony that you stopped working as of January [redacted] 2018, and are currently receiving $195.00 per week in unemployment insurance benefits, or $780.00 per month ($195.00 X 4 weeks).

You further testified that have a monthly transit deduction of $121.00, which you pay to get to work. Since this statement contradicts your claim that you stopped working as of January [redacted] 2018, which is documented in your Unemployment Official Record of Benefit Payment History, and there is no evidence in the record that this was a pre-tax deduction, this factor was not considered in this analysis.

Since your eligibility was conditional and the record now contains a more accurate representation of your household income, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance using monthly income of $780.00 in 2018 and a one-person household, for an individual residing in Kings County, New York, taking into account that you are a noncitizen immigrant.

If your circumstances change, you are required to report any change, such as in income, to NYSOH within 30 days of such change.

Decision

The October 23, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance using monthly income of $780.00 in 2018 and a one-person household, for an individual residing in Kings County, New York, taking into account that you are a noncitizen immigrant, and to notify you accordingly.

Effective Date of this Decision: March 12, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility going forward.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based on the information noted above. NYSOH will issue a notice with its redetermination in due course.

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

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 mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 23, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance using monthly income of $780.00 in 2018 and a one-person household, for an individual residing in Kings County, New York, taking into account that you are a noncitizen immigrant, and to notify you accordingly.

This is not a final determination of your eligibility going forward.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based on the information noted above. NYSOH will issue a notice with its redetermination in due course.

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).