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

Notice of Decision

Decision Date: April 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026677

[redacted]

On March 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 19, 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
  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).

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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).

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

Decision

Decision Date: April 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026677

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine you were eligible for the Essential Plan with a $20.00 monthly premium and ineligible for Medicaid, effective January 1, 2018?

Procedural History

On December 11, 2017, NYSOH received your updated application for financial assistance with your health insurance.

On December 12, 2017, NYSOH issued an eligibility determination notice stating you were conditionally eligible for Medicaid, effective January 1, 2018. The notice directed you to "provide additional information in order to confirm your eligibility," but the notice did not specify what documentation was being sought or any applicable due date.

Also on December 12, 2017, NYSOH issued a notice of enrollment, based on your December 11, 2017 plan selection, confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2018.

On December 18, 2017, NYSOH systematically redetermined your eligibility for health coverage.

On December 19, 2017, NYSOH issued a notice stating you were eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018. The

notice indicated that you were not eligible for Medicaid, because your household income was over the allowable income limit for that program.

Also on December 19, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan enrollment would end on January 1, 2018, because you were no longer eligible to enroll in that plan.

On January 2, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar as you were no longer eligible for Medicaid.

On January 17, 2018, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective January 1, 2018, for a limited time, because you had been granted Aid to Continue pending the decision in your appeal.

Also on January 17, 2018, NYSOH issued an enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2018.

On March 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 March 26, 2018 to allow you to submit supporting documents. As of March 26, 2018, no documents had been received by the Appeals Unit nor were any such documents viewable in your NYSOH account. Therefore, the record was closed that day and this decision is based on the record as developed during the hearing.

Findings of Fact

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

1) On December 11, 2017, NYSOH received an updated application submitted on your behalf. That application indicated you would file your 2018 tax return with a tax filing status of single and you would claim no dependents. You testified that information was accurate.

2) The December 11, 2017 application listed expected annual income for 2018 of $14,400.00 consisting solely of income received from income source "[redacted]

3) Your application indicates you will not take any deductions on your 2018 tax return.

4) NYSOH determined you conditionally eligible for Medicaid, effective January 1, 2018, pending receipt of documentation to verify the income information in your application to confirm your eligibility.

5) You enrolled in a Medicaid Managed Care plan, effective January 1, 2018.

6) On December 18, 2017, NYSOH received the following biweekly paystubs:

   a. Check date of December 1, 2017 showing income of $230.00, with no withholdings, for [redacted] for 1 hour at a rate of $230.00. The check showed year to date earnings of $230.00.

   b. Check date of December 15, 2017 showing income of $1,250.29, with no withholdings, for [redacted] for 1 hour at a rate of $1,250.29. The check showed year to date earnings of $1,480.29.

7) According to your account, NYSOH verified your documentation and recalculated your annual income, based on the average biweekly income in the paystubs provided, as $19,243.77.

8) NYSOH systematically redetermined your eligibility based on the recalculated income amount and found you eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

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

10) You were granted Aid to Continue in your Medicaid Managed Care plan pending the outcome of your appeal.

11) You testified that NYSOH's calculation of your annual household income was not accurate, because a portion of the income shown in your paystubs was actually reimbursement of your out-of-pocket expenses for supplies.

12) You testified that you are contracted as a [redacted] for [redacted], that you earn either $30.00 or $40.00 per hour depending on the work you perform, that you are paid biweekly, and that your hours vary depending on the [redacted].

13) You testified that you pay out of pocket for supplies for your classes.

14) You testified that you invoice "[redacted]" for the cost of supplies you pay for and you are reimbursed in your paycheck.

15) You testified that every paycheck you receive should have a corresponding invoice.

16) You testified that the paystub for the December 1, 2017 pay check was lower, because it was during [redacted]. Your further testified that your records showed that $150.00 of the $230.00 of income show in that paystub was earned income. You testified that the rest was for reimbursement of costs.

17) You testified that the paystub for the December 15, 2017 paycheck was your normal schedule. You testified that your records showed that $250.29 of the $1,250.29 of income shown in that paystubs was for reimbursement of your cost of supplies.

18) You testified that you believe the paystubs submitted only show year to date income received in the month of December 2017, because the employer only began issuing computerized paystubs in December 2017. You testified that previously you had received handwritten business checks for payment.

19) You testified that you expect to make approximately the same amount of income in 2018 as you did in 2017, because you have the same schedule.

20) You testified that you think you will take a business expense deduction in 2018, but you do not know the amount.

21) You were directed to submit documentation of your 2017 income including the form 1099 received from your contract work as well as a letter from the employer detailing the reimbursement system of pay, a letter from you stating the amount of your income received in 2017 that constituted reimbursement of costs with attached corresponding invoices.

22) As of the date of this decision, no additional documentation of your income has been received by NYSOH.

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)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id.*).

Verification Process

For all individuals whose income is needed to calculate the household’s eligibility, NYSOH must request data that will allow NYSOH to verify the household’s income (45 CFR §155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f)).

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 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

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 Federal Register 8831, 8832).

Legal Analysis

The issue is whether NYSOH properly determined you were eligible for the Essential Plan with a $20.00 monthly premium and ineligible for Medicaid, effective January 1, 2018.

The December 11, 2017 updated application submitted on your behalf indicated you would file your 2018 tax return with a tax filing status of single and you would claim no dependents. You testified that information was accurate. The application listed expected annual income for 2018 of $14,400.00 consisting solely of income received from income source "[redacted]." According to your account, NYSOH was unable to verify the information in your application.

Pursuant to the regulations, for all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence. In the eligibility determination notice issued by NYSOH on December 12, 2017, you were advised that your eligibility for Medicaid was only conditional and that additional documentation was needed to confirm your eligibility. However, the notice failed to specify what documentation was being requested nor was a due date for such documentation provided.

Notwithstanding the defective December 12, 2017 eligibility determination notice, on December 18, 2017, you submitted two biweekly paystubs. According to your account, NYSOH verified your documentation and recalculated your annual income, based on the average biweekly income in the paystubs provided, as $19,243.77. NYSOH systematically redetermined your eligibility based on the recalculated income amount and found you eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018. You appealed that eligibility determination insofar as you were not eligible for Medicaid.

At the hearing, you testified that NYSOH's calculation of your annual household income was not accurate, because a portion of the income shown in your paystubs was actually reimbursement of your out of pocket cost for supplies. You

testified that each pay period you invoice your employer for the cost of supplies and that the employer reimburses you for those costs in your paycheck. You testified that every paycheck you receive should have a corresponding invoice. It is noted that the paystubs submitted do not distinguish between income and reimbursement of costs.

Given your testimony that you expect to make approximately the same amount of income in 2018 as you did in 2017, as well as your testimony that the income documentation previously submitted was not representative of your actual income, you were directed to submit updated documentation of your 2017 income detailing the reimbursement system of pay to corroborate your testimony. However, as of the date of this decision, no such documentation has been received.

Based on your testimony that the previously submitted paystubs are not representative of your income and the lack of any additional documentary evidence of your income, it is concluded that there is insufficient evidence in the record of your household income for 2018. As such, there is no factual basis upon which the Appeals Unit can overturn NYSOH's December 19, 2017 eligibility determination notice, stating you were eligible for the Essential Plan with a $20.00 monthly premium and ineligible for Medicaid, effective January 1, 2018. Accordingly, that determination must be AFFIRMED.

Decision

The December 19, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: April 10, 2018

How this Decision Affects Your Eligibility

You remain eligible for the Essential Plan with a $20.00 monthly premium and ineligible for Medicaid.

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 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 December 19, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for the Essential Plan with a $20.00 monthly premium and 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:

[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).