



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

Notice of Decision

Decision Date: May 23, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP0000000029083



Dear [REDACTED]

On May 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 21, 2018 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).

This page intentionally left blank.



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

Decision

Decision Date: May 23, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029083



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 to enroll in the Essential Plan with a premium of \$20.00 per month for a limited time, effective April 1, 2018?

Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On February 20, 2018, you updated your application for financial assistance. That day, NY State of Health (NYSOH), issued a preliminary eligibility determination finding you eligible for the Essential Plan for limited time with a premium of \$20.00 per month, effective April 1, 2018.

Also on February 20, 2018, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not found eligible for Medicaid.

On February 21, 2018, NYSOH issued an eligibility determination notice, consistent with the preliminary eligibility determination, stating that you were eligible to enrolled into the Essential Plan for a limited time, effective April 1, 2018. The notice directed you to provide proof of income by May 21, 2018, to confirm your eligibility.

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).

Also on February 21, 2018, NYSOH issued a disenrollment notice that stated your coverage in your Medicaid Managed Care plan would end on March 31, 2018, because you were no longer eligible to remain enrolled in your current health insurance.

On April 10, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for Medicaid for a limited time. The notice stated that you were granted Aid to Continue until a decision is made on your appeal.

Also on April 10, 2018, a plan enrollment notice was issued confirming your enrollment in a Medicaid Managed Care plan as of April 1, 2018.

On May 4, 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 May 19, 2018, to allow you time to submit supporting documents.

On May 11, 2018, you faxed a copy of four consecutive biweekly paystubs, dated March 9, 2018 through April 20, 2018. These documents were made part of the record as "Appellant's Exhibit A" 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 2018 taxes with a tax filing status of single. You will claim no dependents on that tax return.
- 2) You are seeking health insurance for yourself; specifically, coverage under Medicaid.
- 3) The application that was submitted on February 20, 2018, in which you requested financial assistance, listed annual household income of \$20,280.00 in earnings from your employment. You testified that you were unsure if this amount was correct because your income fluctuates.
- 4) On May 11, 2018, you faxed a copy of four consecutive biweekly paystubs, dated March 9, 2018 through April 20, 2018. These documents show that your 2018 gross annual income is expected to be \$25,784.79, calculated by taking the April 20, 2018 year to date income and dividing it by eight pay periods in which you received income in 2018, then multiplying that amount by 26 pay periods in 2018 ($\$7,933.78/8 = \991.7225×26) (see [REDACTED])

- 5) You testified that your income for February 2018 was \$2,058.08, consisting of two paystubs, dated in February 2018 in the amount of \$1,029.04 each.
- 6) Your application states that you will not be taking any deductions on your 2018 tax return.
- 7) Your application states that you live in [REDACTED], New York.
- 8) You testified that you have bills, including rent, union dues, and transportation expenses that you think should be deducted from your household income.
- 9) According to your NYSOH account, on May 17, 2018 after your hearing was held, NYSOH recalculated your expected 2018 annual income to be recalculated to be \$27,561.17.

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 funds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent, union dues, and certain transportation expenses are not an allowable deduction in computing adjusted gross income (*id.*).

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

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).

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 Federal Register 8831).

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 2018 FPL, which is \$12,140.00 for a one-person household (83 Fed. Reg. 2642).

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 with a premium of \$20.00 per month, effective April 1, 2018.

The application that was submitted on February 20, 2018, listed annual household income of \$20,280.00 and the eligibility determination relied upon that information. During the hearing, you testified that you were unsure if this amount was correct because your income fluctuates. You also testified that you have bills, including rent, union dues, and transportation expenses, that you think should be deducted from your household income.

Since the Internal Revenue Service rules do not allow living expenses 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 APTC purposes. Since this is the income information you provided in your application, it is concluded that NYSOH correctly determined your household income to be \$20,280.00 as of February 20, 2018.

According to your NYSOH account and testimony, you expect to file your 2018 taxes with a tax filing status of single. You 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 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 \$12,060.00.00 for a one-person household. Since an annual household income of \$20,280.00 is 168.16% of the 2017 FPL, NYSOH properly found you to be eligible for the Essential Plan with a premium of \$20.00 per month for a limited time, using the information provided in your application.

The second issue under review is whether NYSOH properly determined that you were found 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 (MAGI) that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$12,140.00 for a one-person household. Since \$20,280.00 is 167.1% of the 2018 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 February 2018 was \$2,058.08, consisting of two paystubs dated in February 2018 in the amount of \$1,029.04 each.

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 \$1,397.00 per month. Since you credibly testified that your income for February 2018 was \$2,058.08, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the February 21, 2018 eligibility determination notice properly stated that, based on the information you provided, you were eligible for the Essential Plan with a premium of \$20.00 per month for a limited time, and ineligible for Medicaid, effective April 1, 2018, it is correct and is AFFIRMED.

However, since your eligibility was conditional and the record now contains a more accurate representation of your 2018 expected modified adjusted gross annual household income of \$25,784.79, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2018, using that income amount and a one-person household, for an individual residing in [REDACTED], New York.

Decision

The February 21, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2018 based on a 2018 annual household income of \$25,784.79 and a one-person household, for an individual residing in [REDACTED], New York.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

Effective Date of this Decision: May 23, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for financial assistance in 2018.

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).

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2018 based on the parameters noted above.

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 case 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

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).

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 February 21, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2018 based on a 2018 annual household income of \$25,784.79 and a one-person household, for an individual residing in [REDACTED], New York.

This is not a final determination of your eligibility for financial assistance in 2018.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2018 based on the parameters noted above.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:



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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. y&b&tumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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).