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

Notice of Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029634

[redacted]

Dear [redacted]

On May 2, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 23, 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).

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

Decision

Decision Date: May 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029634

[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 that you were eligible to enroll in the Essential Plan with a $20.00 premium per month, as of February 23, 2018?

Procedural History

On February 16, 2018, you submitted an application for financial assistance through NYSOH.

On February 17, 2018, NYSOH issued an eligibility determination notice stating that you were conditionally eligible for Medicaid, effective April 1, 2018. The notice instructed you to provide proof of your income by March 3, 2018.

Also on February 17, 2018, NYSOH issued a plann enrollment notice confirming that as of February 16, 2018, you were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of April 1, 2017.

On February 20, 2018, the documentation that you mailed to NYSOH was received (*see* Document [redacted]

On February 22, 2018, your NYSOH account was updated.

On February 23, 2018, NYSOH issued three notices:

(1) An eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 premium per month, effective April 1, 2018;

(2) A plan enrollment notice confirming that as of February 22, 2018, you were enrolled in an Essential Plan with an enrollment start date of April 1, 2018;

(3) A disenrollment notice stating that your MMC plan coverage would end as of March 31, 2018, because you were no longer eligible to enroll in that health plan.

On March 1, 2018, you spoke to NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance you were determined eligible to receive.

On May 2, 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 May 7, 2018, to allow you to submit your last four paystubs to NYSOH's Appeals Unit.

On May 4, 2018, you faxed four-pages of additional income documentation to NYSOH's Appeals Unit. That documentation was made part of the record as "Appellant Exhibit A." 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 expect to file a 2018 federal income tax return with the tax status of single, and you do not expect to claim any dependents on that tax return.

3) According to your February 16, 2018 application, you attested that you expect your annual household to be $14,224.08.

4) You testified that you are employed at [redacted] and that is your only source of income.

5) On February 20, 2018, NYSOH received your last four weekly paystubs from [redacted]. According to the paystubs, you received taxable wages of:

(a) $355.39 on January 26, 2018;
(b) $345.19 on February 2, 2018;
(c) $389.15 on February 9, 2018;
(d) $365.74 on February 16, 2018

(*see* Document [redacted].

6) You testified that you do not expect to claim any deductions on your 2018 federal income tax return.

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

8) You testified that your weekly earnings have recently decreased.

9) On May 4, 2018, you submitted your last four weekly paystubs from [redacted] to NYSOH's Appeals Unit. According to the paystubs you were issued taxable wages of: (1) $351.23 on April 13, 2018; $346.67 on April 20, 2018; $261.23 on April 27, 2018, and $188.59 on May 4, 2018 (see Appellant Exhibit A).

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Verification Process - Income

NYSOH may accept self-attestation of information needed to determine the income eligibility of an individual for Medicaid (42 CFR § 435.945(a)). NYSOH must request information relating to financial eligibility from other agencies in the State, other States, and Federal programs to the extent NYSOH determines such information is useful to verifying the financial eligibility for an individual (42 CFR § 435.948(a)).

An individual must not be required to provide additional information or documentation unless information needed by NYSOH cannot be obtained electronically or the information obtained electronically is not reasonably compatible with information provided by or on behalf of the individual (42 CFR § 435.952(c)).

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.

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 APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). 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).

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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan with a $20.00 premium per month, as of February 23, 2018.

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.

On February 16, 2018, you submitted to NYSOH a financial assistance application. In that application, you attested to an annual household income of $14,224.08. Since the income information that was entered in that application did not match federal and state data sources, on February 17, 2018, NYSOH issued a notice directing you to submit additional income documentation to confirm your eligibility by March 3, 2018.

On February 20, 2018, NYSOH received your last four paystubs from [redacted] (Document [redacted]). Based on the paystubs, your annual household income was calculated to be ($355.39 + $345.19 + $389.15 + $365.74 X 13 periods) $18,920.72. The February 23, 2018 eligibility determination relied upon that information.

You attested that you expect to file a 2018 federal income tax return, with the tax status of single, and did not expect to claim any dependents on that return. Therefore, you were in a one-person household for purposes of this analysis.

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. A person who has a household income greater than 150% of the FPL but below 200% of the FPL has a $20.00 per month premium contribution.

A one-person household with an annual household income of $18,920.72 is 156.89% of the 2017 FPL. Therefore, NYSOH properly found you to be eligible for the Essential Plan with a $20.00 premium as of February 23, 2018, and the February 23, 2018 eligibility determination is AFFIRMED.

You testified that your weekly earnings have recently decreased. On May 4, 2018, you submitted your last four weekly paystubs from [redacted] to NYSOH's Appeals Unit (*see* Appellant Exhibit A). Based on the documentation submitted your expected annual household income is ($351.23 + $346.67 + $261.23 + $188.59 X 13 periods) $14,920.36.

Based on the foregoing, your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, residing in [redacted], New York, with an expected annual household income of $14,920.36.

Decision

The February 23, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, residing in [redacted], New York, with an expected annual household income of $14,920.36.

Effective Date of this Decision: May 10, 2018

How this Decision Affects Your Eligibility

This decision does not change your past eligibility for or enrollment in health insurance coverage through NYSOH.

This decision is not a final determination of your eligibility for financial assistance going forward.

Your case has been returned to NYSOH based on the parameters stated above.

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:

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 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 February 23, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, residing in [redacted], New York, with an expected annual household income of $14,920.36.

This decision does not change your past eligibility for or enrollment in health insurance coverage through NYSOH.

This decision is not a final determination of your eligibility for financial assistance going forward.

Your case has been returned to NYSOH based on the parameters stated above.

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Legal Authority

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A Copy of this Decision Has Been Provided To:

[redacted]

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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।

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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.

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