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

Notice of Decision

Decision Date: May 22, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030220

[redacted]

Dear [redacted]

On May 3, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 16, 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 22, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000030220

[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 2, with additional cost for vision and dental, effective April 1, 2018?
>
> Did NY State of Health properly determine that you were not eligible for the Essential Plan 3 or Medicaid?

Procedural History

On March 15, 2018, you applied for health insurance and financial assistance through NY State of Health (NYSOH).

That day, a preliminary eligibility determination was prepared stating that you were eligible to enroll the Essential Plan 2 with no monthly premium. As part of that preliminary determination, you were given the option to enroll in dental and vision benefits for an additional monthly premium.

Also on March 15, 2018, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you were not eligible to enroll in the Essential Plan 3, including dental and vision benefits at no additional cost.

On March 16, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll the Essential Plan with no monthly premium, and had

the option to enroll in dental and vision benefits for an additional monthly premium, effective April 1, 2018. That notice also stated that you were not eligible for Medicaid, because your annual household income was over the allowable income limits for that program.

Also on March 16, 2018, NYSOH issued an enrollment confirmation notice stating that you were enrolled in an Essential Plan 2 with no monthly premium, with an enrollment start date of June 1, 2017. The notice also stated that the plan selected does not cover dental and vision services and you can change to a plan that covers these services for an additional monthly premium.

On May 3, 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 up to May 10, 2018, to allow you time to submit supporting documentation.

On May 8, 2018, and May 9, 2018, NYSOH received documentation of your income, as well as your lease and utility bills by upload. The documents were incorporated into the record as Appellant's Exhibit #1 and the record was closed.

Findings of Fact

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

1) You testified that you expect to file your tax return for 2018 with a tax filing status of head of household. You will claim two dependents on that tax return.

2) You are seeking insurance for yourself.

3) The application that was submitted on March 15, 2018 listed annual household income of $28,800.00, consisting of income you earn from your employment on a biweekly basis.

4) You testified that you make $15.00 dollars an hour, that you work forty hours a week, and that your income is consistent.

5) You testified that your monthly income for March 2018 was $2,400.00.

6) You provided documentation of two biweekly paystubs from March 2018, one dated March 14, 2018, that showed a gross pay of $1,200.00, and a second dated March 28, 2018 that showed a gross pay of $1,200.00.

7) You also provided documentation of two biweekly paystubs from April 2018, one dated April 11, 2018 that showed a gross pay of $1,200.00, and

a second dated April 25, 2018 that showed a gross pay of $1,200.00, showing that your monthly income for April 2018 was $2,400.00.

8) You testified, and your application states that you will not be taking any deductions on your 2018 tax return.

9) You testified that you do not expect your income to increase or decrease this year, but that you are eligible to request a raise later in the year.

10) You testified, and your application states that you live in Kings County.

11) You testified that you have bills including rent, utilities, and food bills that you think should be deducted from your household income.

12) You testified that the purpose of your appeal was to be found eligible to enroll in the Essential Plan 3.

13) Your application indicates that you are an immigrant non-citizen with a permanent residency card. The grant date of your permanent resident card is listed as [redacted].

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

Applicable Law and Regulations

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 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 $20,420.00 for a three-person household (82 Fed. Reg. 8831).

A person who has a household income of at between 100% and 159% of the FPL has a $0 premium contribution and cost-sharing at Medicaid levels

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 and higher cost-sharing (New York's Basic Health Plan Blueprint, as approved January 2016).

A person is eligible for the Essential Plan 1 if they are between 150%-200% of the FPL. A person is eligible for the Essential Plan 2 if they are between 138%-150% of the FPL (https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20H%20-%20EP%20Benefits%20and%20Cost-Sharing.pdf).

Qualified Immigrants

In NY State, qualified immigrants who were formerly eligible for Medicaid through the state, but not eligible for Medicaid under federal law, were transitioned to the Essential Plan as of January 1, 2016 (New York's Basic Health Plan Blueprint, p. 19, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html). This category of qualified immigrants includes individuals lawfully admitted for permanent residence in the United States who are still in their first five years of permanent residency. (18 NYCRR § 349.3, 8 USC § 1613). The transition population of lawfully present non-citizens up to 138% FPL will receive the same benefits as the non-long term care benefits they had in Medicaid. New York's Basic Health Plan Blueprint, as approved January 2016).

A person who as a household income of at or below 100% of FPL has $0 premium contribution and $0 cost-sharing (New York's Basic Health Plan Blueprint, as approved January 2016).

A qualified immigrant is eligible for the Essential Plan 3 if they are between 100%-138% of the FPL. A qualified immigrant is eligible for the Essential Plan 4 if they are below 100% of the FPL (https://info.nystateofhealth.ny.gov/sites/default/files/Attachment%20H%20-%20EP%20Benefits%20and%20Cost-Sharing.pdf).

Dental Plans for Essential Plan Eligible Applications

A person eligible for the Essential Plan and between 138% – 200% of the FPL will have a premium for the dental and vision portion of their premium if they choose to purchase a plan with dental and vision included (https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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 $20,780.00 for a three-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).

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*.).

Legal Analysis

The first issue under review is whether NYSOH properly determined you were eligible for the Essential Plan 2, with additional cost for vision and dental, effective April 1, 2018.

The application that was submitted on March 15, 2018 listed an annual household income of $28,800.00 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 asked that your current expenses, which include rent, utilities, and food bills, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable, and phone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income. Therefore, NYSOH correctly determined your household income to be $28,800.00 at the time of your application.

You are in a three-person household. You expect to file your 2018 income tax return as head of household and will claim two dependents on that tax return.

The Essential Plan with a $0.00 premium is generally provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 150% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Since an annual household income of $28,800.00 is 141.04% of the 2017 FPL, NYSOH correctly found you to be eligible for the Essential Plan with no monthly premium based on the information in your application.

You filed your appeal in part because you wanted to be able to enroll into an Essential Plan that offers dental and vision services at no extra cost. A person eligible for the Essential Plan between 138% – 200% of the FPL will have a premium for the dental and vision portion of their plan. Since your income is 141.04% of the FPL you would be required to pay additional costs for vision and dental had you chose to enroll in a plan offering such services. Therefore, NYSOH was correct in stating that you had the option to enroll in dental and vision benefits for an additional monthly premium.

The second issue is whether NYSOH properly determined that you were ineligible for the Essential Plan 3 or Medicaid.

You testified that the purpose of your appeal was to be found eligible to enroll in the Essential Plan 3. A qualified immigrant is eligible for the Essential Plan 3 if they are between 100%-138% of the FPL.

However, the Essential Plan 3 is only available to legal permanent residents who are not eligible for Medicaid under federal law due to being in the first five years of their permanent residency.

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 application indicates that you are an immigrant non-citizen with a permanent residency card. The grant date of your permanent resident card is listed as [redacted].

Since you are not within the first five years of your qualified immigration status you would not be able to enroll into the Essential Plan 3 if your income was between 100% -138% of the FPL.

However, 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 $20,780.00 for a three-person household. Since $28,800.00 is 138.59% 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 submitted biweekly paystubs that shows that you received $2,400.00 in March 2018.

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 $2,390.00.00 per month. Since the documentation you provided shows that you earned $2,400.00 in March 2018, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the March 16, 2018 eligibility determination notice properly stated that, based on the information you provided, you were eligible for the Essential Plan 2 with additional costs for vision and dental, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The March 16, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 22, 2018

How this Decision Affects 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).

You remain eligible for the Essential Plan with additional cost for vision and dental services if you choose to enroll into a plan that offers such services.

You are 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 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 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 March 16, 2018 eligibility determination notice is AFFIRMED.

You remain eligible for the Essential Plan.

You are 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.

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