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

Notice of Decision

Decision Date: July 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017994

[redacted]

Dear [redacted],

On July 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 14, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: July 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017994

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Did NY State of Health (NYSOH) properly calculate your household's Modified Adjusted Gross Income when determining your family's eligibility for financial assistance?

Did NYSOH properly determine that your family is not eligible for Medicaid?

Procedural History

On April 13, 2017, NYSOH received your updated application for health insurance. That day, a preliminary eligibility determination was prepared finding you eligible to purchase a qualified health plan at full cost, effective May 1, 2017. That day it was further determined that your family was not eligible for Medicaid.

Also on April 13, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as your family was not eligible for Medicaid.

On April 14, 2017, NYSOH issued an eligibility determination notice, based on the information contained in the April 13, 2017 application, stating that you were eligible to purchase a qualified health plan at full cost, effective May 1, 2017. That notice further stated that your family was not eligible for Medicaid, because the household income you provided was over the allowable limit for that program.

On July 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You are seeking insurance for your family, which includes yourself and your two children.

2) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim two dependents on that tax return, including your oldest child.

3) The application that was submitted on April 13, 2017 listed annual household income of $35,295.54, consisting of $23,550.30 you earn from your employment and $11,745.24 your oldest child earns from [redacted] employment.

4) You testified that your income at the time of your application was correct, but that NYSOH incorrectly counted your oldest child's income when calculating your household income. You further testified that [redacted] is a full-time student and does not contribute [redacted] income to the household.

5) You testified that you and your children have no other sources of income.

6) In April 2017, you submitted your 2016 W-2 Wage and Tax Statement reflecting that in 2016 you received $23,550.30 in gross employment income and a bank statement showing that between March 15, 2017 and April 5, 2017 your oldest child received $974.25 in net employment income, which when multiplied by 12 months equals an expected annual income of $11,691.00 (*see* Documents [redacted].

7) You testified that in April 2017, your gross employment income as $2,560.00 and that your oldest child's income was approximately $1,000.00. This totals a gross monthly household income of $3,560.00.

8) According to your NYSOH account and your testimony, you will not be taking any deductions on your 2017 income tax return.

9) According to your NYSOH account and your testimony, your family lives 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

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)).

With regard to eligibility for financial assistance through NYSOH, a tax filer's household income includes the MAGI of all the individual's in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.46B-1(e)(1); 42 CFR § 435.603(d)(1)). The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

The IRS determines whether a dependent is required to file an income tax return based on the amount of the dependent's earned and unearned income, marital status, age and whether or not that dependent is blind. In cases where the dependent is under the age of 65, not blind and earns an income $6,300.00 or higher during the 2016 income tax year (or unearned income in the amount of $1,050 or higher), that dependent is required to file an income tax return for 2016 (IRS Pub. 929).

Unearned income is generally all income other than salaries, wages and other amounts received as pay for work actually performed, including the taxable part of Social Security and pension payments (IRS Pub. 929).

For the purposes of determining a person's eligibility for financial assistance for health insurance through NYSOH, the term "MAGI" 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)).

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 $20,420.00 for a three-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).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

Reimbursement for Out-of-Pocket Expenses

Although Medicaid payments are generally made only to providers, 18 NYCRR § 360-7.5(a) provides two exceptions in which direct reimbursement of paid medical bills may be made to eligible Medicaid recipients or their representatives.

Under one exception, the regulation provides that Medicaid recipients or their representatives may be reimbursed when, through no fault of their own:

(a) an erroneous Medicaid eligibility determination is reversed (whether the reversal is due to the state or local agency discovering its own error or is the result of a fair hearing decision or court order), or the state or local agency fails to determine Medicaid eligibility within the applicable time periods; and

(b) an erroneous eligibility determination or the delay in determining eligibility caused the recipient or the recipient's representative to pay for medically necessary services which otherwise would have been paid for by the Medicaid program.

(18 NYCRR §360-7.5(a)(3)(i).

Legal Analysis

The first issue under review is whether NYSOH properly calculated your household's Modified Adjusted Gross Income used when determining your family's eligibility for financial assistance.

The application that was submitted on April 13, 2017 listed annual household income of $35,295.54, consisting of $23,550.30 you earn from your employment and $11,745.24 your oldest child earns from her employment. The eligibility determination relied upon that information.

Household income for the purposes of calculating a person's eligibility for financial assistance to help pay for the costs of health insurance through NYSOH, consists of the modified adjusted gross income of all tax filers in a household who are required to file a tax return. You testified that your income at the time of your application was correct, but that NYSOH incorrectly counted your oldest child's income in your family's eligibility determination because she is a full-time student and does not contribute her income to your household.

However, a dependent is required to file a tax return for 2016 when their earned income is greater than $6,300.00. On the date of your application, you attested that your child had annual income of $11,745.24. At an income of $11,745.24, [redacted] would be required to file a tax return and [redacted] income would therefore be included in your family's household's income.

Therefore, NYSOH properly determined your household income to be $35,295.54, based on the income information you provided in your family's application.

The second issue under review is whether NYSOH properly determined that your family was ineligible for Medicaid.

As stated above, the application that was submitted on April 13, 2017 listed an annual household income of $35,295.54 and the eligibility determination relied upon that information.

You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim two dependents on that tax return, including your oldest child, [redacted]. Therefore, your household consists of three people.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65, and children between the ages of one and 19, who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% and 154% of the FPL for the applicable family size, respectively. On the date of your application, the relevant FPL was $20,420.00

for a three-person household. Since $35,295.54 is 172.85% of the 2017 FPL, NYSOH properly found your family to be ineligible for Medicaid on an expected annual income basis, using the information you 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 credibly testified that, in April 2017, you resided in a three-person household and your gross household income that month was $3,560.00, consisting of $2,560.00 you received in employment income and $1,000.00 your oldest child received in employment income.

To be eligible for Medicaid, you and your oldest child, and your youngest child, would need to meet the non-financial criteria and have an income no greater than 138% and 154% of the FPL, respectively. This calculates to $2,349.00 per month at 138% of the FPL and $2,621.00 per month at 154% of the FPL for a three-person household. Since you credibly testified that your household received a gross income of $3,560.00 in April 2017, your family does not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the April 14, 2017 eligibility determination notice properly stated that, based on the information you provided, your family was not eligible for Medicaid, it is correct and is AFFIRMED.

Finally, to qualify for Medicaid reimbursement of third-party insurance premiums and out-of-pocket expenses, you must be eligible for Medicaid. Since your family was not eligible for Medicaid upon your family's renewal for 2017, your family is not eligible for reimbursement of out-of-pocket expenses through the Medicaid program.

Decision

The April 14, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: July 28, 2017

How this Decision Affects Your Eligibility

This decision does not change your family's eligibility.

Your family is not eligible for Medicaid.

Since your family is not eligible for Medicaid, your family is not eligible for reimbursement of out-of-pocket expenses through the Medicaid program.

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 April 14, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your family's eligibility.

Your family is not eligible for Medicaid.

Since your family is not eligible for Medicaid, your family is not eligible for reimbursement of out-of-pocket expenses through the Medicaid program.

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.

☒☒☒ (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.

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).

□□□□□ **(Bengali)**

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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 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 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.

(Urdu) اردو

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.

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).

(Yiddish) אידיש

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).