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

Notice of Decision

Decision Date: December 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021744

[redacted]

[redacted]

On November 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 24, 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: December 1, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021744

[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 (MAGI), which was used to determine your eligibility for financial assistance?

Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On August 23, 2017, NYSOH received your updated application for health insurance. That day, a preliminary eligibility determination was prepared finding you eligible to enroll in the Essential Plan with a premium of $20.00 per month, effective October 1, 2017.

Also on August 23, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not eligible for Medicaid.

On August 24, 2017, NYSOH issued an eligibility determination notice, consistent with the preliminary eligibility determination, stating that you were eligible to enroll in the Essential Plan with a premium of $20.00 per month, effective October 1, 2017. That notice further stated that you were not eligible for Medicaid, because the household income you provided is over the allowable limit for that program.

On November 13, 2017, 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 November 28, 2017, to allow you time to submit supporting documents.

On November 13, 2017, you submitted your Unemployment Benefit Statement, a letter of attestation that your oldest child had no paycheck in August 2017, and a self-generated wage report for your oldest child, dated May 5, 2017 through November 3, 2017. These documents were made part of the record as "Appellant's Exhibit A."

On November 16, 2017, you submitted a letter from your employer. This document was made part of the record as "Appellant's Exhibit B."

On November 20, 2017, you submitted your Social Security Disability Benefits Statement. This document was made part of the record "Appellant's Exhibit C."

No further documentation was received as of November 28, 2017 and the record closed that day.

Findings of Fact

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

1) You are seeking Medicaid for yourself.

2) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim only your oldest child as a dependent.

3) The application that was submitted on August 23, 2017, listed annual household income of $25,724.00, consisting of $18,684.00 you receive in Social Security benefits and $7,040.00 your oldest child receives in income from her 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 testified that she is a full-time student and does not contribute her income to the household.

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

6) Your August 23, 2017 application states that your oldest child's monthly income is the same as in the current month.

7) On November 13, 2017, you submitted a letter of attestation stating that your oldest child did not receive a paycheck in August 2017, because she was [redacted] during the summer, along with a self-generated statement of your oldest child's net pay for the period of May 5, 2017 through November 3, 2017. These documents show that your child works for a retail store and has an average bi-weekly net income of $528.46. It does not show your child's year-to-date gross income or that your child did not work in the month of August 2017 (*see* Appellant's Exhibit A, pp. 3 - 6).

8) You testified that your income for the month of August 2017 was $1,557.00.

9) You further testified that you were not sure of your oldest child's income in August 2017 but that it was probably lower because the month of August is in the slow season.

10) On November 20, 2017, you submitted your 2017 Social Security Disability benefits statement showing that you receive $1,730.00 gross per month in Social Security benefits.

11) Your August 23, 2017 application states that your income for August 2017 is $2,093.67, consisting of $1,507.00 you received in Social Security Disability Benefits and $586.67 your oldest child received in employment income.

12) According to your NYSOH account and your testimony, you will be taking a $600.00 tuition and fees deduction in 2017.

13) According to your NYSOH account and your testimony, you live in Westchester County, 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 (MAGI) 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. Based on the most recent publication, in cases where the dependent is under the age of 65, not blind, and earns an income $6,300.00 or higher during 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 that year (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 $16,240.00 for a two-person household (82 Federal Register 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).

Legal Analysis

The first issue under review is whether NYSOH properly calculated your household's MAGI, which was used to determine your eligibility for financial assistance.

The application that was submitted on August 23, 2017 listed annual household income of $25,724.00, consisting of $18,684.00 you receive in Social Security Benefits and $7,040.00 your oldest child receives in income from her employment. Your application further states that you will be taking a $600.00 tuition and fees deduction on your tax return. As such, your household MAGI for 2017 was calculated to be $25,124.00. 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 MAGI 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 eligibility determination because she is a full-time student and does not contribute her income to your household.

However, according to the IRS' most recent publication, a dependent is required to file a tax return 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 $7,040.00. At an income of $7,040.00, she would be required to file a tax return and her income would therefore be included in your household's income.

Therefore, NYSOH properly determined your household income to be $25,124.00, based on the income information you provided in your application.

The second issue under review is whether NYSOH properly determined that you were not eligible for Medicaid.

As stated above, the application that was submitted on August 23, 2017 listed an annual household income of $25,124.00 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 one dependent on that tax return; that is, your oldest child, who is [redacted]. Therefore, your household consists of two people.

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% the FPL for the

applicable family size, respectively. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $25,124.00 is 154.70 % 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 testified that, in August 2017, you resided in a two-person household and your income for the month of August 2017 was $1,557.00. However, your submitted documents, which serve as the best evidence, show that you received a Social Security benefit in the gross amount of $1,730.00 in the month of August 2017.

You further testified that you were not sure of your oldest child's income in August 2017, but that it was probably lower because the month of August is in the slow season.

On November 13, 2017, you submitted a letter of attestation stating that your oldest child did not receive a paycheck in August 2017.

Your testimony that your oldest child did not receive a paycheck and had no income in August 2017, conflicts with the information in your August 23, 2017 application, which states that your oldest child's monthly income is the same as in the current month. This statement also conflicts with your own testimony that your child worked in August 2017, but since it was the slow season, her paychecks would be less, as well as your statement that she did not work in August 2017 because she was [redacted] during the summer. In totality, your testimony as to your child's August 2017 income is conflicting and therefore, is not credible., Further, the documents you submitted on November 13, 2017, are insufficient to show your that your child did not work in the month of August 2017.

Therefore, based on the credible evidence of record, it is concluded that NYSOH properly determined your monthly income for August 2017 to be $2,093.67, based on the income information you provided in your application.

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, respectively. This calculates to $1,868.00 per month for a two-person household. Since the credible evidence of the record shows that your household received a gross income of $2,093.67 in August 2017, you did not qualify for Medicaid on the basis of monthly income as of the date of your application.

The same outcome would apply using your increased monthly income of $1,730.00, along with your child's income as calculated by NYSOH for August 2017.

Since the August 24, 2017 eligibility determination notice properly stated in relevant part that, based on the information you provided, you were not eligible for Medicaid. Therefore, it is correct and is AFFIRMED.

Decision

The August 24, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: December 1, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

You were properly determined to be ineligible for Medicaid.

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
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The August 24, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

You were properly determined to be 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:

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).

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।

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.

(Yiddish)אידיש

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).

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).