STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: February 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024914

[redacted]

[redacted]

On February 6, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 18, 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
  PO 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 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(b).

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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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, effective January 1, 2018?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid, as of the November 18, 2017 redetermination of eligibility?

Procedural History

On November 2, 2017, NYSOH received (1) a letter issued by [redacted], dated October 25, 2017, stating that your child was employed by [redacted], and his most recent day worked was October 6, 2017, and (2) an earnings statement reflecting that his year to date income of as October 27, 2017 was $3,811.50.

On November 17, 2017, NYSOH received an update to your application for financial assistance with health insurance. Based on the information contained within this update, NYSOH prepared a preliminary eligibility determination stating that you were conditionally eligible for Medicaid, pending receipt of income documentation to confirm the information contained within that application was accurate.

Also on November 17, 2017, NYSOH received (1) a Social Security notice of award issued to you confirming your monthly benefit amount beginning January 2017, (2) an Official Record of Benefit Payment History issued to your child as of

November 13, 2017, confirming his benefits paid to him between August 24, 2017 and November 13, 2017.

Finally, on November 17, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On November 18, 2017, NYSOH issued an eligibility determination notice stating that you were found eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

Also on November 18, 2017, NYSOH issued an enrollment notice confirming your selection of an Essential Plan as of November 17, 2017, with such coverage to begin effective January 1, 2018.

On November 28, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not eligible for Medicaid. You also were seeking a review of whether you properly found eligible for the Essential Plan with a coverage start date of January 1, 2018.

On December 21, 2017, NYSOH received a letter from [redacted] in support of your request for an expedited appeal.

On December 27, 2017, NYSOH issued a notice confirming that your request for an appeal on an expedited basis was denied because the documents you submitted did not provide sufficient evidence to meet the standard required for the expedited appeals process.

On February 6, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: an updated version of an Official Record of Benefit Payment History issued to your child reflecting his unemployment benefits to date. The record was to be closed as of February 7, 2018, or upon the receipt of the above referenced documents, whichever occurred earlier.

That same day, you provided the above referenced documents to the Appeals Unit through by facsimile, and the record was closed on February 6, 2018.

Findings of Fact

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

1) You testified that you were seeking an appeal of your eligibility only since your child had been found eligible for Medicaid.

2) Your application reflects that you expect to file your 2017 taxes with a tax filing status of single, and that you will claim your child as a dependent on that tax return.

3) You are seeking insurance for yourself.

4) On November 17, 2017, you provided to NYSOH (1) a Social Security notice of award issued to you confirming your monthly benefit amount beginning January 2017 was in the amount of $1,670.90, (2) an Official Record of Benefit Payment History issued to your child as of November 13, 2017, confirming his benefits paid to him between August 24, 2017 and November 13, 2017 in the amount of $145.00 per week beginning August 24, 2017.

5) Your eligibility was redetermined on November 17, 2017 by NYSOH, which listed annual household income of $24,965.30, consisting of (1) $1,670.90 per month in Social Security benefits you anticipate receiving during 2017, (2) $145.00 per week in unemployment benefits your child anticipated receiving during the remaining 7 weeks of 2017, and (3) $3,899.50 in earnings your child received from [redacted] during 2017.

6) Your application states that you will not be taking any deductions on your 2017 tax return.

7) You live in [redacted] New York.

8) On February 6, 2018, you provided to NYSOH an updated version of an Official Record of Benefit Payment History issued to your child reflecting his unemployment benefits to date. This document confirms that your child received $145.00 in unemployment benefit payments on November 6, 2017, November 13, 2017, November 20, 2017 and November 27, 2017.

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 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 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 2016 FPL, which is $16,020.00 for a two-person household (80 Fed. Reg. 3236, 3237).

Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

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 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).

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), 42 CFR § 603(e), *see* 26 USC § 36B(d)(2)(B)).

With regard to eligibility for financial assistance through NYSOH, a tax filer's household income includes the MAGI of all the individuals in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.36B-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)).

A person is not required to file a tax return if their gross income is less than the sum of the exemption amount plus the basic standard deduction allowable for that person (26 USC § 6012(1)(A)). For the 2017 year, a dependent who had yearly gross earned income greater than $6,300.00 or gross unearned income greater than $1,050.00 would be required to file a tax return (see IRS Revenue Procedure 2014-61).

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 Publication 929, pg. 15).

For the purposes of determining a person's eligibility for financial assistance for health insurance through the Marketplace, 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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective January 1, 2018.

Your eligibility for financial assistance was redetermined on November 17, 2017 based on the documentation you provided between November 2, 2017 and November 17, 2017. This redetermination of eligibility listed an annual household income of $24,965.30, consisting of (1) $1,670.90 per month in Social

Security benefits you anticipate receiving during 2017, (2) $145.00 per week in unemployment benefits your child anticipated receiving during the remaining 7 weeks of 2017, and (3) $3,899.50 in earnings your child received from [redacted] during 2017.

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 attested to your intent to file a 2017 return when you requested financial support on the NYSOH application. Since you plan on filing your taxes as head of household and claim your child as a dependent on your 2017 tax return, you are in a two-person household.

A dependent will be required to file a tax return in 2017 if their earned income is greater than $6,300.00. According to the information on your application and your testimony, your grandchild has no earned income. Since your dependent has an earned income less than $6,300.00, he is not required to file a tax return based on his earned income.

A dependent will also be required to file a tax return in 2017 when their unearned income is greater than $1,050.00.

Based on your testimony, and the documents you submitted, your child will receive $3,899.50 in earned income during 2017, and $1,576.88 in unearned income between August 28, 2017 and December 24, 2017. Accordingly, your child would be required to file taxes. Accordingly, your child's income is included within your MAGI for purposes of determining your eligibility since you are claiming him as a dependent.

Therefore, your total income during 2017 should have been based a total household income of $25,527.18 on (1) $20,050.80 you anticipate receiving from your Social Security benefits, (2) $3,899.50 you child earned from [redacted] and (3) $1,576.88 you received in unemployment benefits during 2017.

You are in a two-person household. You expect to file your 2017 income taxes as single and will claim your child as a dependent on that tax return.

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 $16,020.00 for a two-person household. Since an annual household income of $25,527.18 is 159.35% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan.

The second issue is whether NYSOH properly determined that you were not eligible for Medicaid as of the November 17, 2017 redetermination.

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 $16,240.00 for a two-person household. Since $25,527.18 is 157.19% of the 2017 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 your Social Security notice of award reflecting that you received $1,670.90, and submitted a revised Official Record of Benefit Payment History reflecting that your child received a total of $580.00 in unemployment benefits, during the month of your revised application, November 2017.

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 $1,868.00 per month. Since the documentation you provided shows that your household received $2,250.90 during November 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the corrected household income figures would not have resulted in a material change of your eligibility, finding you eligible for the Essential Plan, effective January 1, 2018, and not eligible for Medicaid, it was correct and is AFFIRMED.

Decision

The November 18, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 12, 2018

How this Decision Affects Your Eligibility

You were eligible for coverage through the Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

You are not eligible for Medicaid at this time.

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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The November 18, 2017 eligibility determination notice is AFFIRMED.

You were eligible for coverage through the Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

You are not eligible for Medicaid at this time.

Legal Authority

We are issuing this determination 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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