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

Notice of Decision

Decision Date: March 02, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025096

[redacted]

Dear [redacted],

On January 9, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 28, 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 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(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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Decision

Decision Date: March 02, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025096

[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 you were eligible for the Essential Plan with a $20.00 monthly premium, and not eligible for Medicaid, effective January 1, 2018?

Procedural History

On January 1, 2017, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective January 1, 2017. You enrolled into a Medicaid Managed Care plan, effective February 1, 2017.

On October 28, 2017, NYSOH issued a notice indicating that your coverage for the 2018 coverage year was being automatically renewed pursuant to a systematic redetermination of your eligibility based on information obtained from state and data sources indicating your annual income was between $18,090.00 and $24,120.00. The notice indicated that you qualified for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018. The notice further indicated that you no longer qualified for Medicaid, effective December 31, 2017.

On November 17, 2017, NYSOH issued a disenrollment notice stating your Medicaid Managed Care plan coverage would end on December 31, 2017, because you were no longer eligible for that plan.

Also on November 17, 2017, NYSOH issued an enrollment notice confirming your automatic enrollment in an Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

On November 30, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were no longer eligible for Medicaid.

On January 9, 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 to January 31, 2018 for you to submit supporting documentation. On January 30, 2017 and January 31, 2017, you uploaded documentation to your NYSOH account. These documents were collectively incorporated into the record as Appellant's Exhibit # 1. The record closed thereafter.

Findings of Fact

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

1) On January 7, 2017, NYSOH determined you eligible for Medicaid, effective January 1, 2017, based on an annual expected income of $1,708.00.

2) On October 7, 2017, NYSOH systematically redetermined your eligibility for financial assistance for 2018 based on income information obtained from state and federal data sources indicating your annual income was between $18,090.00 and $24,120.00.

3) Based on that income information, NYSOH determined you eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

4) You were disenrolled from your Medicaid Managed Care plan, effective December 31, 2017, and automatically enrolled into an Essential Plan, effective January 1, 2018.

5) You appealed insofar as you were no longer eligible for Medicaid.

6) You testified that you have been unemployed since 2010, because you are caring for your sick mother.

7) You testified that your only income source is IRA distributions.

8) You testified that you will take at least as much in IRA distributions in 2018 as you did in 2017, but likely more in 2018.

9) You were directed to submit proof of the amount of IRA distributions you took in 2017.

10) You testified that, at the time of the hearing, you had not yet filed your 2017 tax return.

11) On January 30, 2018, you uploaded a form 1099-R showing IRA distributions in the taxable amount of $31,000.00 in 2017 from '[redacted]' to '[redacted]' ([redacted]2).

12) According to your account, you had previously submitted a copy of your 2016 tax return showing adjusted gross income of $23,586.00 including $23,500.00 in "IRA distributions" [redacted] as well as a form1099-R showing IRA distributions in the taxable amount of $23,500.00 in 2016 from '[redacted]' to '[redacted]' ([redacted]).

13) According to your account, you had also previously submitted a copy of your 2015 tax return showing adjusted gross income of $36,092.00 including $37,800.00 in "IRA distributions" ([redacted]) as well as a form 1099-R showing IRA distributions in the taxable amount of $37,800.00 in 2015 from '[redacted]' to '[redacted]' ([redacted]).

14) According to your account, all applications submitted by you or on your behalf between 2016 and January 31, 2018 attest to annual expected income of $0.00.

15) You testified, and your applications indicate, you will file your 2017 tax return with a tax filing status of single and you will claim no dependents.

16) You testified that at the time of the hearing, you had not yet filed your 2017 tax return.

17) You testified, and your applications indicate, you reside in [redacted].

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

Applicable Law and Regulations

Essential Plan Eligibility

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 $11,880.00 for a one-person household (81 Federal Register 4036).

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, as approved January 2016; *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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, *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

Medicaid Eligibility

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 $12,060.00 for a one-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 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 issue is whether NYSOH properly determined you were eligible for the Essential Plan with a $20.00 monthly premium, and not eligible for Medicaid, effective January 1, 2018.

On October 7, 2017, NYSOH systematically redetermined your eligibility for financial assistance for 2018 based on income information obtained from state and federal data sources indicating your annual income was between $18,090.00 and $24,120.00. Based on that income information, NYSOH determined you eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018. You appealed insofar as you were no longer eligible for Medicaid.

You testified that you have been unemployed since 2010, because you are caring for your sick mother. You further testified that your only income source is IRA distributions. You testified that you will take, at least, as much in IRA distributions in 2018 as you did in 2017, but likely more in 2018.

On January 30, 2018, you uploaded a form 1099-R showing IRA distributions in the taxable amount of $31,000.00 in 2017 from "[redacted]" to "[redacted]." Based on that documentation as well as previously submitted evidence, including tax returns for 2015 and 2016 showing the full amount of IRA distributions taken in each year included in the adjusted gross income calculation on those returns, it is concluded that your adjusted gross income in 2017 was, at least, $31,000.00. Since you testified that you will take, at least, as much in IRA distributions in 2018 as you did in 2017, it is concluded that your adjusted gross income in 2018 will be, at least, $31,000.00.

Since the record establishes that the October 28, 2017 eligibility determination at issue was based on data sources indicating your annual income was between $18,090.00 and $24,120.00, less than the amount as establishes by the evidence, that determination is no longer supported by the record and must be RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, as of October 28, 2018, based on a household size of one and the now developed record evidencing your expected annual income for 2018 is, at least, $31,000.00.

Decision

The October 28, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, as of October 28, 2018, based on a household size of one and an annual income for 2018 of $31,000.00

Effective Date of this Decision: March 02, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility for 2018.

Your case is being sent back to NYSOH to redetermine your eligibility based on the new evidence of your annual income.

You will receive an updated eligibility determination notice from NYSOH.

PLEASE NOTE: Any APTC you receive for 2018 must be reconciled on your 2018 federal income tax return. Be advised that enrollees who take more tax credit in advance than they eventually claim on their tax return for that year will owe the difference as additional income tax.

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 appeal 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 October 28, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, as of October 28, 2018, based on a household size of one and an annual income for 2018 of $31,000.00

This is not a final determination of your eligibility for 2018.

Your case is being sent back to NYSOH to redetermine your eligibility based on the new evidence of your annual income.

You will receive an updated eligibility determination notice from NYSOH.

PLEASE NOTE: Any APTC you receive for 2018 must be reconciled on your 2018 federal income tax return. Be advised that enrollees who take more tax credit in advance than they eventually claim on their tax return for that year will owe the difference as additional income tax.

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.

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).