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

Notice of Decision

Decision Date: March 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025507

[redacted]

Dear [redacted],

On February 26, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 6, 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: March 9, 2018

NY State of Health Account ID: [redacted]
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[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?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid?

Procedural History

On December 6, 2017, NY State of Health (NYSOH) issued an eligibility determination notice, based on the December 5, 2017 application, stating that you were eligible to enroll into the Essential Plan with a $20.00 monthly premium, effective January 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.

On December 6, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan with a $20.00 monthly premium, effective January 1, 2018.

Also on December 7, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not eligible for Medicaid.

On December 21, 2017, NYSOH issued a notice stating that you were eligible for Medicaid, for a limited time, effective January 1, 2018. This was because you had been granted Aid to Continue pending the outcome of your appeal.

Also on December 21, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a Medicaid Managed Care plan, effective January 1, 2018.

On February 12, 2018, you had a scheduled telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. That day you requested that the hearing be adjourned, which was granted.

On February 26, 2018, you had and adjourned hearing with a Hearing Officer from the NYSOH's Appeals Unit. Under oath, you waived your right to formal notice of the telephone hearing. 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) The application that was submitted on December 6, 2017, indicates that you expect to file your tax return for 2018 with a tax filing status of single and will claim no dependents on that tax return.

2) During the hearing, you testified that you expect to file your tax return for 2018 with a tax filing status of single, but that you expect to claim one dependent on that tax return.

3) You testified that you expect to claim your [redacted], who has been residing with you, as a dependent on your 2018 federal tax return. You testified that:

    a. Your friend is [redacted]
    b. Your friend is not related to you;
    c. You are receiving no compensation from her;
    d. Your friend has no income;
    e. You are providing at least 51% of her support; and
    f. You are not sure when she will be moving out, but expect that she will be staying with you for the whole year.

4) You are seeking health insurance for yourself.

5) The application that was submitted on December 5, 2017, listed an annual household income of $22,620.00, consisting of $11,220.00 you receive from your Social Security Disability benefits and $11,400.00 you receive in

income from your [redacted]. You testified that this amount was correct.

6) Your application states that you will not be taking any deductions on your 2018 tax return. However, you testified that you may take certain expenses related to your [redacted] as a deduction on your 2018 tax return, but that you were unsure as to the amount because you have not filed taxes since 2014.

7) You testified, and provided documentation to show, that your monthly income for December 2017 was $1,885.00.

8) You testified that you are not eligible for nor are you receiving Medicare.

9) You testified that you have other bills that you also need to pay and, due to your fixed income, you are unable to afford your health insurance unless you qualify for Medicaid.

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 $12,060.00 for a one-person household (82 Federal Register 8831).

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, p. 21, as approved January 2016; see https://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).

The Essential Plan is considered minimum essential coverage. Therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual marketplace (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

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 $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).

Household Compensation

"Family size" means the number of persons counted as members of an individual's household. The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents (42 CFR § 435.603(f)(1)).

A taxpayer can claim a person as a dependent if that person is a qualifying relative. To be considered a qualifying relative, the person must meet the following criteria:

1. The person cannot be your qualifying child or the qualifying child of any other taxpayer; and

2. The person either (a) must be related to you in one of the ways recognized by the Internal Revenue Service (IRS) as a relative who do not have to live with you, or (b) must live with you all year as a member of your household and the relationship must not violate local law; and

3. The person's gross income for the year must be less than $4,050.00; and

4. You must provide more than half of the person's total support for the year

(IRS Publication 515, pg. 12).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan.

The application that was submitted on December 5, 2017 listed an annual household income of $$22,620.00 and the eligibility determination relied upon that information.

Based on the information provided to NYSOH on December 5, 2017, you are in a one-person household. The application indicates that you expect to file your 2018 income tax return as single and will claim no dependents on that tax return.

The Essential Plan 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 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household.

Since an annual household income of $22,260.00 is 187.56% of the 2017 FPL, NYSOH correctly found you to be eligible for the Essential Plan, based on the information in your application.

The second issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

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 $12,060.00 for a one-person household. Since $22,620.00 is 187.56% 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 testified, and provided documentation indicating, that you receive $935.00 per month in Social Security Disability benefits, and $950.00 per month in income from your [redacted]. Therefore, your monthly household income is $1,885.00.

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 $1,387.00 per month. Since the documentation you provided shows that you earned $1,885.00 in December 2017, you did not qualify for Medicaid based on monthly income as of the date of your application on December 6, 2017.

Since the December 6, 2017 eligibility determination notice properly stated that, based on the information you provided, you are eligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

During the hearing, you testified that while your application states you will claim no dependents on your 2018 federal tax return, you now plan on claiming one dependent on your 2018 federal tax return.

The household of a taxpayer who expects to file a return, and does not expect to be claimed as a tax dependent by anyone else, consists of the taxpayer plus all people the taxpayer expects to claim as tax dependents. The IRS allows a taxpayer to claim a person as a dependent on their tax return if that person is a qualifying relative. To be considered a qualifying relative, the person must satisfy the following: (1) the person cannot be your qualifying child or the qualifying child of any other taxpayer , (2) the person either (a) must be related to you in one of the ways recognized by the IRS as a relative who do not have to live with you, or (b) must live with you all year as a member of your household and the relationship must not violate local law, (3) the person's gross income for the year must be less than $4,050.00, and (4) you must provide more than half of the person's total support for the year.

You testified that your [redacted] has been staying with you and you plan on claiming her as a dependent on your 2018 federal tax return. You further testified that you are not related to her, you expect that she will be residing with you for the entire year, she has no income, you are receiving no compensation from her, and you provide at least 51% of her support while she is living with you. Therefore, the record supports a finding that you can file your 2018 federal tax

return with a tax filing status of single and can claim one dependent on that tax return, if you so choose.

NYSOH's Appeals Unit does not have the authority to change a consumer's tax filing status on their application. You will need to contact NYSOH and update your application to reflect a change in your tax filing status, if you so choose.

Decision

The December 6, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 9, 2018

How this Decision Affects Your Eligibility

NYSOH properly determined that you were eligible for the Essential Plan, based on the information provided in your application.

NYSOH properly determined that you were ineligible for Medicaid, based on the information provided in your application.

You will need to contact NYSOH and update your application to reflect a change in your tax filing status, if you so choose.

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 December 6, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined that you were eligible for the Essential Plan.

NYSOH properly determined that you were ineligible for Medicaid.

You will need to contact NYSOH and update your application to reflect a change in your tax filing status, if you so choose.

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).