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

Notice of Decision

Decision Date: April 09, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000027784

[redacted]

On April 3, 2018, your authorized representative, [redacted], appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 2018, 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.

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).

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545.

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

Decision

Decision Date: April 09, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000027784

[redacted]

[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 that you were ineligible for Medicaid as of January 18, 2018?

Procedural History

On January 16, 2018, an application for financial assistance was submitted through NYSOH.

Also on January 16, 2018, additional income documentation was uploaded to your NYSOH account (**see** Documents [redacted]

On January 17, 2018, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. The notice directed you to submit proof of income by January 31, 2018, to confirm your eligibility.

Also on January 17, 2018, your NYSOH account was systemically updated.

On January 18, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 premium per month, effective as of March 1, 2018. The notice further stated that you were ineligible for Medicaid because your household income was over the allowable income limit.

On January 25, 2018, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as you were determined ineligible for Medicaid.

On April 3, 2018, your authorized representative had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until April 4, 2018, to allow you to submit additional income documentation to NYSOH's Appeals Unit.

On April 3, 2018, two-pages of documentation was faxed to NYSOH's Appeals Unit. That documentation was made part of the record as "Appellant Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) According to your NYSOH account, you are seeking health insurance for yourself.

2) According to your NYSOH account, at all times relevant, you were [redacted].

3) You filed your 2017 federal income tax return with the tax filing status of single, and did not claim any dependents on that return (*see* Appellant Exhibit A).

4) According to your NYSOH account, you expect to file your 2018 federal income tax return with a tax filing status of single, and do not expect to claim any dependents on that tax return.

5) According to your January 16, 2018 application, your only source of income is from pension and annuities, and you expect to receive $10,356.77 in 2018.

6) On January 16, 2018, your Variable Annuity Quarterly Statement, from [redacted] was submitted to NYSOH. The statement reflects that you were issued $24,000.00 from January 1, 2017 through December 31, 2017; and your year-to-date taxable distributions were $10,356.99 (*see* Document [redacted]

7) According to your NYSOH account, on January 17, 2018, NYSOH updated your application to reflect that your expected yearly income was $24,000.00.

8) On April 3, 2018, your 2017 Form 1040 federal income tax return was submitted to NYSOH's Appeals Unit. Line 37 of the return reflects that your adjusted gross income was $10,357.00 (*see* Appellant Exhibit A).

9) Your authorized representative testified that your annuity is your only source of income and you would be receiving less in 2018.

10) Your authorized representative testified that you want to be found eligible for Medicaid and not the Essential Plan.

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)). 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)).

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 2018 FPL, which is $12,140.00 for a one -person household (83 Federal Register 2642).

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).

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).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were ineligible for Medicaid as of January 18, 2018.

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 $12,140.00 for a one-person household.

The record reflects that you expect to file your 2018 federal income tax return with the tax status of single, and do not expect to claim any dependents on that return. Therefore, you are in a household of one for purposes of this analysis.

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 $16,754.00 for a one-person household.
There is nothing in the record to indicate that you would not meet the nonfinancial requirements for Medicaid. Therefore, the analysis turns to the financial requirements.

On January 16, 2018, your NYSOH account was updated and you attested to an income of $10,356.77. Based on that attestation, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources and directed you to submit proof of income by January 31, 2018, to confirm your eligibility.

On January 16, 2018, your Variable Annuity Quarterly Statement, from [redacted] was submitted to NYSOH. The statement reflects that you were issued $24,000.00 from January 1, 2017 through December 31, 2017. Further, that your year-to-date taxable distributions were $10,356.99 (*see* Document [redacted]

On April 3, 2018, your 2017 Form 1040 federal income tax return was submitted to NYSOH's Appeals Unit. Line 37 of the return reflects that your adjusted gross income was $10,357.00 (*see* Appellant Exhibit A). Further, your authorized representative testified that your annuity is your only source of income and would be receiving less in 2018.

Since your expected 2018 income of $10,357.00 or less will not exceed the maximum allowable monthly income amount of $16,754.00, you did qualify for Medicaid based on your expected income as of the date of your application.

Your authorized representative testified that you want to be found eligible for Medicaid and not the Essential Plan. Individuals who are eligible for Medicaid are not eligible to enroll in the Essential Plan.

The January 18, 2018 eligibility determination improperly stated that you were ineligible for Medicaid and is RESCINDED.

Your case is RETURNED to NYSOH redetermine your eligibility for Medicaid as of January 18, 2018, using a one-person household with an annual income of $10,357.00 for an individual, and to allow you to enroll into an appropriate plan as of March 1, 2018.

Decision

The January 18, 2018 eligibility determination improperly stated that you were ineligible for Medicaid and is RESCINDED.

Your case is RETURNED to NYSOH redetermine your eligibility for Medicaid as of January 18, 2018, using a one-person household with an annual income of $10,357.00 for an individual, and to allow you to enroll into an appropriate plan as of March 1, 2018.

Effective Date of this Decision: April 09, 2018

How this Decision Affects Your Eligibility

You were improperly determined eligible to enroll in the Essential Plan.

NYSOH failed to determine you eligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your eligibility for Medicaid based on the parameters noted above.

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 January 18, 2018 eligibility determination improperly stated that you were ineligible for Medicaid and is RESCINDED.

Your case is RETURNED to NYSOH redetermine your eligibility for Medicaid as of January 18, 2018, using a one-person household with an annual income of $10,357.00 for an individual, and to allow you to enroll into an appropriate plan as of March 1, 2018.

You were improperly determined eligible to enroll in the Essential Plan.

NYSOH failed to determine you eligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your eligibility for Medicaid based on the parameters noted above.

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]

[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।

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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 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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