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

Notice of Decision

Decision Date: April 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013879

[redacted]

Dear [redacted],

On March 22, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 29, 2016 eligibility determination.

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 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).

This page intentionally left blank.

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

Decision

Decision Date: April 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013879

[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 to enroll in the Essential Plan effective December 1, 2016?
>
> Did NY State of Health properly determine that you were ineligible for Medicaid?
>
> Did NY State of Health properly determine that your children were eligible to enroll in Child Health Plus with a $9.00 monthly premium per child, effective December 1, 2016?
>
> Did NY State of Health properly determine that your children were ineligible for Medicaid?

Procedural History

On September 21, 2016, NY State of Health (NYSOH) received your household's updated application for financial assistance. That day, income documentation was uploaded to your NYSOH account.

On September 22, 2016, NYSOH issued a notice advising you that the information you provided did not match what NYSOH had received from state and federal data sources and that additional information was needed to confirm the information in your application. This notice also directed you to submit income documentation for your household by October 6, 2016.

On September 30, 2016, NYSOH reviewed the income documentation you submitted on September 21, 2016 and determined that this was insufficient to resolve the inconsistency in your account as income documentation was needed for your older child.

On October 1, 2016, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional proof of your household's income was due by October 21, 2016.

On October 21, 2016, additional income documentation was uploaded to your NYSOH account.

On October 28, 2016, NYSOH reviewed the income documentation you submitted and recalculated your household income based on this information. That day, an application was submitted on your behalf including this recalculated household income.

On October 29, 2016, NYSOH issued a notice of eligibility determination, based on the October 28, 2016 application, stating that you were eligible to enroll in the Essential Plan and that your children were eligible for Child Health Plus with a $9.00 monthly premium per child, effective December 1, 2016. It further stated that neither you nor your children qualified for Medicaid, as you were over the income level for that program.

On December 7, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you and your children were not eligible for Medicaid.

On March 22, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for seven days to allow you the opportunity to submit additional income documentation. On March 27, 2017, the Appeals Unit received via fax five paystubs. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

Findings of Fact

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

1) You testified that you expect to file your 2016 tax return with a tax filing status of head of household. You will claim two dependents on that tax return.

2) You are seeking Medicaid for yourself and your children as of September 1, 2016.

3) The record reflects that at the time of your September 21, 2016 application and October 28, 2016 application, your children were 17 and 14 years old.

4) You testified that you have held one job throughout 2016 and continue to work for the same employer. You testified that you earn $19.00 per hour and currently work approximately 20 hours per week. You noted that your hours vary. You explained that in the second half of 2016 you were earning more because your supervisor had left and you were covering the supervisory position. You also explained that your current income has decreased because the supervisor position has been filled, so you are no longer working extra hours to cover that position.

5) You testified that in 2016 your children were selected to work for the summer through the [redacted] You testified that your children's earnings through this program were less than $1,000.00 each.

6) You submitted seven paystubs; the first is for pay date August 26, 2016 for a gross pay amount of $1,778.65; the second is for pay date September 9, 2016 for a gross pay amount of $774.25; the third is for pay date September 23, 2016 for a gross pay amount of $1,231.58; the fourth is for pay date January 27, 2017 for a gross pay amount of $557.27; the fifth is for pay date February 10, 2017 for a gross pay amount of $549.67; the sixth is for pay date February 24, 2017 for a gross pay amount of $282.15; the seventh is for pay date March 10, 2017 for a gross pay amount of $311.98.

7) The application that was submitted on September 21, 2016, which requested financial assistance, listed annual household income of $26,521.75, consisting of wages you earn from your employment. You testified that you were not sure what your income was for 2016 as your wages varied based on how many hours per week you worked.

8) On October 28, 2016 NYSOH recalculated your household income to be $33,187.70 ($1,778.65 + $774.25 = $2,552.90 divided by 4 weeks = $638.23/ week multiplied by 52 weeks), and updated your application based on this calculation.

9) You testified, and provided documentation, that your monthly income for September 2016 was $2,005.83.

10) Your application states that you will not be taking any deductions on your 2016 tax return. You testified that you may be taking a deduction for

tuition and fees, but you are not sure what the amount of the deduction will be.

11) Your application states, and you testified, that you reside in [redacted] County.

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 2015 FPL, which is $20,090.00 for a three-person household (80 Fed. Reg. 3236, 3237).

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/basic-health-program.html).

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).

Medicaid For Adults Age 19 or Older and Under Age 65

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 2016 FPL, which is $20,160.00 for a three-person household (81 Fed. Reg. 4036).

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).

Child Health Plus

Child Health Plus (CHP) is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (*see* New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be "eligible for medical assistance"; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child's family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from $9.00 per month to $60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is $9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than $27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

In an analysis of Child Health Plus 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 2016 FPL, which is $20,160.00 for a three-person household (81 Fed. Reg. 4036).

Medicaid for Children

A child who is at least one year of age but younger than nineteen is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 154% of the FPL for the applicable family size (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

In the case of an individual who expects to file a tax return and does not expect to be claimed by another taxpayer, the household consists of the taxpayer and all persons whom such individual expects to claim as a tax dependent (42 CFR § 435.603(f)(1).

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 2016 FPL, which was $20,160.00.00 for a three-person household (81 Federal Register 4036).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective December 1, 2016.

The application that was submitted on October 28, 2016 listed an annual household income of $33,187.70 based upon the income documentation you submitted and the eligibility determination relied upon that information.

You are in a three-person household. You expect to file your 2016 income taxes as head of household and will claim two dependents 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 $20,090.00 for a three-person household. Since an annual household income of $33,187.70 is 165.20% of the 2015 FPL, NYSOH properly found you to be eligible for the Essential Plan.

The second issue 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 $20,160.00 for a three-person household. Since $33,187.70 is 164.62% of the 2016 FPL,

NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the income documentation you submitted.

The third issue under review is whether NYSOH properly determined that your children were eligible to enroll in Child Health Plus with a $9.00 monthly premium per child.

Your children are in a three-person household. You expect to file your 2016 income taxes as head of household and will claim two dependents on that tax return.

The application that was submitted on October 28, 2016 listed an annual household income of $33,187.70 based upon the income documentation you submitted and the eligibility determination relied upon that information. Your children were 17 and 14 years old at the time of that application.

A child is eligible to enroll in Child Health Plus if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 160% and 222% of the FPL are responsible for a $9.00 per month per child, Child Health Plus premium payment. On the date of your application, the relevant FPL was $20,160.00 for a three-person household. Since $33,187.70 is 164.62% of the 2016 FPL, NYSOH properly found your child to be eligible for Child Health Plus with a $9.00 monthly premium per child.

The fourth issue is whether NYSOH properly determined that your children were ineligible for Medicaid.

Medicaid can be provided through NYSOH to children between the ages of one and nineteen who meet the non-financial requirements and have a household MAGI that is at or below 154% of the FPL for the applicable family size. Since $33,187.70 is 164.62% of the 2016 FPL for a three-person household, NYSOH properly found your child to be ineligible for Medicaid.

Since the October 29, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan and your children were eligible for Child Health Plus with a $9.00 monthly premium per child, it was correct and is AFFIRMED.

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 paystubs that show in September 2016 you received $2,005.83 in income.

Since the record now contains a more accurate representation of what your household's monthly income is, your case is RETURNED to NYSOH to redetermine your and your children's eligibility as of September 1, 2016 based on a three-person household, residing in [redacted] County, with monthly household income of $2,005.83.

Decision

The October 29, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your children's eligibility as of September 1, 2016 based on a three-person household, residing in [redacted] County, with monthly household income of $2,005.83.

Effective Date of this Decision: April 3, 2017

How this Decision Affects Your Eligibility

This is not a final determination with regard to your and your children's eligibility.

Your case is being sent back to NYSOH to redetermine your and your children's eligibility as of September 1, 2016 based on the information you provided during your hearing.

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 October 29, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your children's eligibility as of September 1, 2016 based on a three-person household, residing in [redacted] County, with monthly household income of $2,005.83.

This is not a final determination with regard to your and your children's eligibility.

Your case is being sent back to NYSOH to redetermine your and your children's eligibility as of September 1, 2016 based on the information you provided during your hearing.

Legal Authority

We are sending you this notice in accordance with 45 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).

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 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.

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).