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

Notice of Decision

Decision Date: April 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014681

Dear [redacted],

On April 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 20, 2016 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: April 19, 2017

NY State of Health Account ID
Appeal Identification Number: AP000000014681

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, effective February 1, 2017?

Did NY State of Health properly determine that your child was eligible for Child Health Plus, effective February 1, 2017?

Did NY State of Health properly determine that you and your child were ineligible for Medicaid?

Procedural History

On December 20, 2016, NY State of Health (NYSOH) issued an eligibility determination notice, based on your December 19, 2016 updated application, stating that you were eligible for the Essential Plan for a limited time and your child was eligible for Child Health Plus, both effective February 1, 2017. That notice further stated that your child was not eligible for Medicaid because her household income was over the allowable income limits for that program.

On January 6, 2017, you spoke to NYSOH's Account Review Unit and appealed only your ineligibility for Medicaid. You also requested that your coverage continue in your Medicaid Managed Care plan pending the outcome of the appeal process.

On January 18, 2017, NYSOH issued an eligibility redetermination notice stating that you were conditionally eligible for Aid to Continue through Medicaid until a decision is made on your appeal, effective January 1, 2017.

On February 17, 2017, NYSOH issued an enrollment confirmation notice stating in part that you were enrolled in a Medicaid Managed Care plan effective January 1, 2017, and that your child was enrolled in a Child Health Plus plan, effective February 1, 2017.

On April 4, 2017, 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 allow you to submit supporting documents.

On April 4, 2017, you submitted your 2016 executed income tax return along with your 2016 W-2 wage statement. These documents were made part of the record collectively as "Appellant's Exhibit A." 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 2017 taxes using a tax filing status of head of household. You will claim one dependent on that tax return.

2) According to your appeal and your testimony, you are seeking to have your eligibility redetermined for Medicaid.

3) According to a March 3, 2017 telephone recording, you requested to have your child's eligibility for Medicaid added to your appeal.

4) The application that was submitted on December 19, 2016 listed annual household income of $24,700.00, based on your gross earnings from employment. You testified that this amount was incorrect.

5) You testified that your certified application counselor based your income off the paystubs you provided at that time. You further testified that those paystubs were higher than usual because your hours vary, and you have never made $24,700.00 per year working for your employer.

6) You testified, and provided documentation showing, that your 2016 annual household income was $20,638.24. You further testified that you expect your income to remain the same in 2017 (*see* Appellant's Exhibit A, p. 2).

7) You testified, and provided documentation showing, that you did not take any deductions on your 2016 tax return (*see* Appellant's Exhibit A, pp. 3-4).

8) According to your NYSOH account and your testimony, you live in [redacted] [redacted], New York.

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

Applicable Law and Regulations

<u>Essential Plan</u>

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 (81 Fed. Reg. 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, 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).

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 market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

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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)).

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 was $16,020.00 for a two-person household (81 Fed. Reg. 4036).

De Novo Review

The Marketplace Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "*De novo review* means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

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).

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 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

Legal Analysis

Initially and per your NYSOH account, it is noted that your appeal related to your eligibility for financial assistance as of February 1, 2017. However, you testified at hearing that you are appealing both your and your child’s eligibilities, on which the Hearing Officer agreed to receive testimony.

The first issue under review is whether NYSOH properly determined that you were eligible for the Essential Plan, effective February 1, 2017.

You expect to file as head of household for the 2017 tax year and claim your one child as a dependent. Therefore, you and your child are in a two-person household for purposes of these analyses.

In your December 19, 2016 application, you attested to an expected household income of $24,700.00. NYSOH relied upon this information.

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The Essential Plan is 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 $16,020.00 for a two-person household. Since an annual household income of $24,700.00 is 154.18% of the 2016 FPL, NYSOH properly found you to be eligible for the Essential Plan, based on the income information you provided in your application.

Since the December 20, 2016 eligibility determination notice properly stated in part that you were eligible for the Essential Plan, effective February 1, 2017, based on the information in your NYSOH account at that time, it is correct and must be AFFIRMED as to your eligibility.

The second issue under review is whether NYSOH properly determined that your child was eligible for Child Health Plus, effective February 1, 2016.

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 for the applicable family size.

On the date of your application, the relevant FPL was $16,020.00 for a two-person household. Since $24,700.00 is 154.18% of the 2016 FPL, and your child would have been ineligible for Medicaid based on that calculation, NYSOH properly found your child to be eligible for Child Health Plus.

Since the December 20, 2016 eligibility determination notice properly stated in part that your child was eligible for Child Health Plus, effective February 1, 2017, based on the information obtained by NYSOH, it is correct and must be AFFIRMED as to your child.

Therefore, the remaining issue under review is whether NYSOH properly determined that you and your child were ineligible for Medicaid.

On January 6, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal of your eligibility determination; specifically, that you wanted to be redetermined eligible for Medicaid. The record does not contain a notice of eligibility determination or redetermination on the issue of your request for Medicaid. It does contain a December 20, 2016 notice in which the NYSOH states that your child is ineligible for Medicaid based on your household income, a January 7, 2017 notice that acknowledges you as the appellant and identifying the issue on appeal as "Eligibility Determination," and a telephone record dated March 3, 2017 indicating that you requested to add your child to your appeal.

Here, the lack of a notice of eligibility determination on the issue of Medicaid eligibility does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to

appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination. The record, including the notices and telephone recording, demonstrates that you did request an appeal on your eligibility determination and to add your child's eligibility determination to the appeal as it relates to your eligibilities for Medicaid. Therefore, it is reasonable to find that this evidence constitutes an appeal on the issue of your and your child's eligibilities for Medicaid and permits an inference that NYSOH did deny your and your child's request to be determined eligible for Medicaid.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to any notice of eligibility determination had it been issued. Therefore, the issue under review is refined to whether NYSOH properly found you and your child ineligible for Medicaid as of January 1, 2017.

The application that was submitted on December 19, 2016 listed annual household income of $24,700.00, consisting of $24,700.00 you earned from your employment in 2016. However, you credibly testified that your certified application assistant incorrectly calculated your annual household income based on the paystubs you provided. You submitted your 2016 income tax return and your Form W-2 to show that in 2016 you received $20,638.24 in gross earnings. You testified that this amount is what you expect to earn in 2017, as well.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 and to children between the ages of one and 19 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for an adult and 154% of the FPL for a child, for the applicable family size.

Since the record now contains a more accurate representation of what your 2017 expected annual household income is, your case is RETURNED to NYSOH to redetermine your and your child's eligibility for financial assistance as persons residing in [redacted], who are members of a two-person household and have an expected 2017 household income of $20,638.24.

Decision

The December 20, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your child's eligibility for financial assistance as persons residing in [redacted], who are members of a two-person household and have an expected 2017 household income of $20,638.24. NYSOH is further directed to notify you of its

redetermination and what further action may be required on your part, if applicable.

Effective Date of this Decision: April 19, 2017

How this Decision Affects Your Eligibility

While your and your child's eligibility for financial assistance was based on information available to NYSOH at that time and, therefore, was correct then, your case is being sent back to NYSOH to redetermine your and your child's eligibility based on the evidence you presented at and after the hearing.

At present, you have Medicaid coverage as of January 1, 2017 as aid to continue during the appeal process and your child has Child Health Plus as of February 1, 2017. Your respective enrollments will not be disturbed until your eligibilities are redetermined by NYSOH. NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

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 December 20, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your child's eligibility for financial assistance as persons residing in [redacted], who are members of a two-person household and have an expected 2017 household income of $20,638.24. NYSOH is further directed to notify you of its redetermination and what further action may be required on your part, if applicable.

While your and your child's eligibility for financial assistance was based on information available to NYSOH at that time and, therefore, was correct then, your case is being sent back to NYSOH to redetermine your and your child's eligibility based on the evidence you presented at and after the hearing.

At present, you have Medicaid coverage as of January 1, 2017 as aid to continue during the appeal process and your child has Child Health Plus as of February 1, 2017. Your respective enrollments will not be disturbed until your eligibilities are redetermined by NYSOH. NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

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 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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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 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.

(Urdu) اردو

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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