



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

## Notice of Decision

Decision Date: May 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015038

[REDACTED]

Dear [REDACTED],

On April 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 19, 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: May 10, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015038



## 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 and your spouse were eligible for the Essential Plan with a \$20.00 monthly premium, effective February 1, 2017?

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

Did NY State of Health properly determine that your children were eligible for Child Health Plus with a \$9.00 monthly premium, effective February 1, 2017?

Did NY State of Health properly determine that your children were ineligible for Medicaid?

## Procedural History

On November 14, 2016, you submitted your updated application for financial assistance with your family's health insurance.

On November 15, 2016, NYOSH issued a notice stating that additional information was needed in order to confirm your, your husband's and your two children's eligibility. This notice further directed you to submit this income documentation by November 29, 2016.

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).

Also on November 15, 2016, NYSOH issued an eligibility determination notice stating that your youngest child remained eligible for Medicaid. The notice also requested that you submit additional income documentation in order to determine your and your other household members' eligibility by November 29, 2016.

On November 21, 2016, you uploaded three documents to your NYSOH account.

On November 25, 2016, you uploaded four documents to your NYOSH account.

On November 28, 2016, you uploaded six documents to your NYOSH account.

On December 7, 2016, NYSOH verified and partially validated your income documentation. NYSOH invalidated some of the income documentation because you did not submit four weeks of consecutive paystubs.

On December 7, 2016, NYOSH issued a notice stating that the documentation you submitted did not confirm the information in your account, and requested that you submit additional income documentation for your spouse and your children by December 29, 2016, and additional income documentation for yourself by January 6, 2017.

On December 29, 2016, you uploaded nine documents to your NYOSH account.

On January 18, 2017, NYSOH verified and validated the documents you submitted on December 29, 2016 and updated your household's application for financial assistance.

Also on January 18, 2017, NYSOH received the updated application for financial assistance with your family's health insurance.

On January 19, 2017, NYOSH issued an eligibility determination notice stating that you and your spouse were eligible for the Essential Plan with a \$20.00 monthly premium, effective February 1, 2017, and your children were eligible for Child Health Plus with \$9.00 monthly premiums, effective February 1, 2017. This notice further directed you to submit additional proof of income for you and your husband by April 18, 2017.

On January 23, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as your family was not found eligible for Medicaid.

On April 19, 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 May 4, 2017, to allow you to submit your 2016 Income Tax Return.

On May 3, 2017, the Appeals Unit received your 2016 Joint Tax Return. This document was made part of the record as Appellant's Exhibit #1, and the record was closed that day.

## **Findings of Fact**

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

- 1) You are seeking insurance for yourself and your family.
- 2) On December 29, 2016, you uploaded a copy of your spouse's paystubs, your paystubs, and self-attestation letters confirming that you and your spouse support your minor children listed on your NYSOH account.
- 3) The application that was submitted on January 18, 2016 listed annual household income of \$46,621.85, consisting of \$300.00 you earn from your employment and \$46,321.85 your spouse receives from his employment. You testified that this amount was incorrect.
- 4) You testified that your spouse has two jobs; one of the jobs is full time, while the other is part-time.
- 5) You further testified that you believe the NYSOH representative that verified your income documentation mistakenly used the wrong job when calculating your and your family's eligibility.
- 6) You provided your 2016 Joint Tax Return, which shows an adjusted gross income of \$37,056.00.
- 7) You testified that you expect your 2017 household income to stay the same as it was in 2016.
- 8) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim three dependents on that tax return.
- 9) Your application states that you will not be taking any deductions on your 2017 tax return.
- 10) Your application states that you live in Wayne County, NY.

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

## **Applicable Law and Regulations**

### Verification Process

For all individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

### 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 2016 FPL, which is \$28,440.00 for a five -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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## 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 2016 FPL, which is \$28,440.00 for a five -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)).

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The CHP premium is \$15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than \$54.00 per month per family (NY PHL § 2510(9)(d)(iii)).

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 \$28,440.00 for a five-person household (80 Federal Register 3236, 3237).

### 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 \$28,440.00 for a five-person household (81 Federal Register 4036).

## **Legal Analysis**

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

For all individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income.

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

You updated your NYSOH account on November 14, 2016. The income amount that was entered into this application did not match federal and state data sources. As a result, NYSOH asked that you submit additional documentation to confirm your income.

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On December 29, 2016, you uploaded a copy of your spouse's paystubs, your paystubs, and self-attestation letters confirming that you and your spouse support your minor children. On January 18, 2017, NYSOH verified those paystubs as acceptable proofs of income. NYSOH recalculated your spouse's income from \$35,498.00 to \$46,321.85 and a new application was submitted on your household's behalf.

However, you testified that the amount that NYOSH calculated was incorrect. You testified that your household income for 2016 was substantially less than \$46,321.85.; which is what MYSOH entered as your household income in your January 18, 2017 application.

After the hearing, you submitted your filed 2016 Joint Tax Return for review, which shows an annual gross income of \$37,056.00 for 2016. You testified that this amount should stay about the same for 2017.

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 \$28,440.00 for a five-person household.

Based on the credible evidence of record, it is reasonable to infer that the NYSOH miscalculated the income that was stated in the January 18, 2017 application, and had the application listed the proper income amount you and your spouse would have been found ineligible for the Essential Plan.

The second issue under review is whether NYSOH properly determined that you and your spouse 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 \$28,440.00 for a five-person household.

Based on the credible evidence of record, it is reasonable to infer that the NYSOH miscalculated the income that was stated in the January 18, 2017 application, and had the application listed the proper income amount you and your spouse would have been found eligible for Medicaid.

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

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 Child Health Plus premium payment. On the date of your application, the relevant FPL was \$28,440.00 for a five-person household.

Based on the credible evidence of record, it is reasonable to infer that the NYSOH miscalculated the income that was stated in the January 18, 2017 application, and had the application listed the proper income amount your children would not have been found eligible for Child Health Plus with \$9.00 monthly premium payments.

The fourth issue is whether NYSOH properly determined that your children were not eligible 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 modified adjusted gross income (MAGI) that is at or below 154% of the FPL for the applicable family size.

Based on the credible evidence of record, it is reasonable to infer that the NYSOH miscalculated the income that was stated in the January 18, 2017 application, and had the application listed the proper income amount your children would have been found eligible for Medicaid.

Since the January 19, 2017 eligibility determination incorrectly stated that you and your spouse were eligible for the Essential Plan, your children were eligible for Child Health Plus, and you, your spouse and your children were ineligible for Medicaid, it is RESCINDED.

Since the record now contains more accurate income information regarding your household, your case is being RETURNED to NYSOH to redetermine your household's eligibility based on a household of five people, residing in Wayne county, with an annual expected income of 37,056.00, and to notify you of the outcome accordingly.

## **Decision**

The January 19, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your household's eligibility based on a household of five people, residing in Wayne county, with an annual expected income of 37,056.00, and to notify you accordingly.

**Effective Date of this Decision:** May 10, 2017

## **How this Decision Affects Your Eligibility**

Your case is being RETURNED to NYSOH to redetermine your household's eligibility for financial assistance and insurance affordability programs based on a household of five people, residing in Wayne county, with an annual expected income of 37,056.00, and to notify you accordingly.

## **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

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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):**

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- 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 19, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your household's eligibility for financial assistance and insurance affordability programs based on a household of five people, residing in Wayne county, with an annual expected income of 37,056.00, and to notify you accordingly.

### **Legal Authority**

We are sending you this notice in accordance with 45 CFR § 155.545.

**A Copy of this Decision Has Been Provided To:**



## 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 مجاناً.

### 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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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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