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

Notice of Decision

Decision Date: May 4, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015125

[redacted]

Dear [redacted],

On April 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 12, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 4, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015125

[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 and your oldest three children were eligible to purchase a qualified health plan at full cost through NYSOH, and not eligible for financial assistance with health insurance?

Procedural History

On January 11, 2017, you updated your household's application for financial assistance with health insurance.

On January 12, 2017, NYSOH issued a notice of eligibility determination stating that you and your three oldest children were eligible to purchase a qualified health plan at full cost through NYSOH, effective February 1, 2017, and not eligible for Medicaid or Child Health Plus. This was because you and your oldest two children were qualified for coverage under another NYSOH account and because federal and state data sources show that your third oldest child was already enrolled in Medicaid, Child Health Plus, or another program.

On January 24, 2017, you spoke to NYSOH's Account Review Unit and appealed this eligibility determination insofar as you and your three oldest children were not eligible for financial assistance with health insurance.

On April 20, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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) You testified that you have coverage through your employer which began on February 1, 2017, and for which you pay $75.00 to $80.00 from each biweekly paycheck.

2) You testified that you previously had Medicaid through NYSOH for November or December 2016 only.

3) You testified that your oldest child is currently enrolled in a full cost qualified health plan. You testified that your oldest child does not have coverage outside of NYSOH, and last had coverage outside of NYSOH when she was enrolled in Medicaid through your local Department of Social Services, which ended July 2016.

4) You testified that your second oldest child is currently enrolled in a full cost qualified health plan. You testified that your oldest child does not have coverage outside of NYSOH, and last had coverage outside of NYSOH when she was enrolled in Medicaid through your local Department of Social Services, which ended July 2016.

5) You testified that your third oldest child currently has Medicaid through your local Department of Social Services.

6) You testified that you intend to file your 2017 tax return with a tax filing status of head of household, and will claim your two oldest children as dependents on that return.

7) The application that was submitted on January 11, 2017 listed annual household income of $27,976.00, consisting of wages you earn from your employment. This application states that you will not be taking any deductions on your 2017 tax return.

8) You testified that for 2017 you will be claiming approximately $3,500.00 in deductions for tuition.

9) You testified that you are currently working one job. You explained that your hours vary and that you sometimes work overtime.

10) The most recent paystub uploaded to your NYSOH account is for the pay period November 13, 2016 through November 26, 2016 which notes a pay date of December 1, 2016 and a year to date gross pay amount of $25,269.74.

11) Your application states, and you confirmed, that you reside in Albany County.

12) A second account exists with regard to your household, [redacted]. Pursuant to incident [redacted] this file was made inactive on January 31, 2017.

13) Pursuant to information in account [redacted], you were enrolled in the Essential Plan under that account from July 1, 2016 through August 31, 2016, and enrolled in fee-for service Medicaid from November 1, 2016 through December 31, 2016, and your two oldest children were enrolled in fee-for service Medicaid under this account from April 1, 2016 through August 31, 2016.

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

Applicable Law and Regulations

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)).

Third Party Health Insurance

A person who has primary medical or health care coverage available from or under a third-party insurance provider is not permitted to enroll into a Medicaid Managed Care plan (NY Social Services Law (NY SSL) § 364-j(3)(e)(xx); Medicaid Managed Care Model Contract (Appendix H-6), effective 3/1/2014 – 2/28/2019). However, they will remain eligible for fee-for-service Medicaid with limited exceptions, including entering prison or another facility that provides medical care, lack of state residence, or failing to provide a valid social security number (NY SSL § 366(4)(c)).

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).

Advance Payments of Premium Tax Credit

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

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, or have health care coverage under insurance (NY PHL § 2511(2)(b),(c)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your oldest three children were eligible to purchase a qualified health plan at full cost through NYSOH, and not eligible for financial assistance with health insurance.

Individuals who are otherwise eligible for and enrolled in mandatory coverage under a State's Medicaid State plan, are not eligible for Medicaid through NYSOH.

Individuals who are otherwise eligible for minimum essential coverage except through the individual market, are not eligible for the Essential Plan or advance payments of the premium tax credit.

Children who are eligible for Medicaid or have health care coverage under insurance are not eligible for Child Health Plus.

On January 11, 2017, you updated your household's application for financial assistance with health insurance. As a result of that application, you and your two oldest children were found eligible to purchase a qualified health plan at full cost through NYSOH, effective February 1, 2017, because you were qualified for coverage on another NYSOH account.

However, the record reflects that at the time of your January 11, 2017 application, neither you, nor your oldest two children were qualified for coverage on your other NYSOH account, nor did you have other coverage outside of NYSOH.

As a result of your January 11, 2017 application, your third oldest child was found eligible to purchase a qualified health plan at full cost through NYSOH, effective February 1, 2017, because federal and state data sources showed that he was already enrolled in Medicaid, Child Health Plus, or another program.

You testified that your third oldest child has Medicaid directly through your local Department of Social Services.

As your third oldest child is enrolled in Medicaid outside of NYSOH, your child is not eligible to enroll in Medicaid through NYSOH. Additionally, as your child is enrolled in Medicaid, your child is not eligible for Child Health Plus.

Therefore, the January 12, 2017 notice of eligibility determination is RESCINDED insofar as it found you and your two oldest children eligible to purchase a qualified health plan at full cost through NYSOH and ineligible for financial assistance. The January 12, 2017 notice of eligibility determination is AFFIRMED insofar as it found your third oldest child eligible to purchase a qualified health plan at full cost through NYSOH and ineligible for financial assistance through NYSOH.

Your case is RETURNED to NYSOH to redetermine your and your oldest two children's eligibility for financial assistance based on a household of three people, residing in Albany County, with an annual expected income of $24,476.00 and to ensure that your other NYSOH account [redacted] is

inactive. NYSOH is further directed to update your account to reflect that you have coverage through your employer which began on February 1, 2017, and for which you pay $75.00 to $80.00 from each biweekly paycheck.

Decision

The January 12, 2017 notice of eligibility determination is RESCINDED insofar as it found you and your two oldest children eligible to purchase a qualified health plan at full cost through NYSOH and ineligible for financial assistance.

The January 12, 2017 notice of eligibility determination is AFFIRMED insofar as it found your third oldest child eligible to purchase a qualified health plan at full cost through NYSOH.

Your case is RETURNED to NYSOH to redetermine your and your oldest two children's eligibility for financial assistance based on a household of three people, residing in Albany County, with an annual expected income of $24,476.00 and to ensure that your other NYSOH account [redacted] is inactive. NYSOH is further directed to update your account to reflect that you have coverage through your employer which began on February 1, 2017, and for which you pay $75.00 to $80.00 from each biweekly paycheck.

Effective Date of this Decision: May 4, 2017

How this Decision Affects Your Eligibility

This is not a final determination on your and your oldest two children's eligibility.

Your third oldest child remains eligible to purchase a qualified health plan at full cost through NYSOH.

Your case is being sent back to NYSOH to redetermine your and your oldest two children's eligibility for financial assistance with health insurance.

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 12, 2017 notice of eligibility determination is RESCINDED insofar as it found you and your two oldest children eligible to purchase a qualified health plan at full cost through NYSOH and ineligible for financial assistance.

This is not a final determination on your and your oldest two children's eligibility.

The January 12, 2017 notice of eligibility determination is AFFIRMED insofar as it found your third oldest child eligible to purchase a qualified health plan at full cost through NYSOH.

Your third oldest child remains eligible to purchase a qualified health plan at full cost through NYSOH.

Your case is RETURNED to NYSOH to redetermine your and your oldest two children's eligibility for financial assistance based on a household of three people, residing in Albany County, with an annual expected income of $24,476.00 and to ensure that your other NYSOH account [redacted] is inactive. NYSOH is further directed to update your account to reflect that you have coverage through your employer which began on February 1, 2017, and for which you pay $75.00 to $80.00 from each biweekly paycheck.

Your case is being sent back to NYSOH to redetermine your and your oldest two children's eligibility for financial assistance with health insurance.

Legal Authority

We are issuing this determination 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.

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