



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

## Notice of Decision

Decision Date: June 12, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015559

[REDACTED]

Dear [REDACTED],

On May 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 7, 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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## Decision

Decision Date: June 12, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000015559

[REDACTED]

## Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health properly determine that your children were not eligible to enroll in a Medicaid Managed Care plan as stated in the January 7, 2017 eligibility determination notice?

## Procedural History

On January 6, 2017, NY State of Health (NYSOH) received your updated application for health insurance for you and your children.

On January 7, 2017, NYSOH issued an eligibility determination notice stating in part that your children remained eligible for Medicaid, effective January 1, 2017. That notice further stated that the type of Medicaid your children were eligible for did not require or allow you to enroll them in a health plan.

Also on January 7, 2017, NYSOH issued a plan enrollment notice confirming your children were enrolled in Medicaid through NYSOH and that no further action was required on your part because the type of Medicaid coverage the children were eligible for did not require or allow you to enroll them in a health plan.

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).

On February 6, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as your children were not allowed to enroll in a Medicaid Managed Care plan.

On May 10, 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 are appealing only your children's eligibility.
- 2) According to your NYSOH account, on the application that was filed on January 6, 2017 you attested to an annual household income of \$40,301.01, and stated that you would file your taxes as head of household with qualifying individuals and would claim four dependents on your tax return. You testified that this information was correct.
- 3) According to your NYSOH account and your testimony, your children are eligible for health insurance through your employer.
- 4) According to your NYSOH account, on January 6, 2017, you submitted a chart showing the employer sponsored health insurance plans that were available and the 2017 bi-weekly rates for each plan. According to that chart, the bi-weekly cost of the least expensive self-only health plan offered in your county for employees earning less than \$41,756.00 annually was \$40.10 (see Documents [REDACTED] and [REDACTED]).
- 5) You testified that, while your children have Medicaid Fee-For-Service, there are no medical, dental or vision care providers located anywhere near you that accept that coverage.
- 6) You testified that it is not affordable to purchase health insurance for your children through your employer-sponsored health plans.
- 7) According to your NYSOH account and your testimony, you and your children reside in Schoharie County, New York.

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

## **Applicable Law and Regulations**

### 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 Department of Social Services Administrative Directive 13ADM-03).

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). Family size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

The Department of Health must make Medicaid coverage start retroactively for up to three months prior to the month of application if the individual received medical services that would have been covered under Medicaid and the individual would have been eligible for Medicaid at the time he received the services if he had applied. (42 CFR 435.915(a)). The Department of Health may make eligibility effective for fee-for-service Medicaid on the first day of the month if an individual was eligible any time during that month (42 CFR 435.915(b)).

### Employer-Sponsored Insurance

An employee who may enroll in an employer-sponsored health insurance plan and individuals who may enroll in the plan because of a relationship to the employee are considered eligible for minimum essential coverage as long as the plan “is affordable and provides minimum value” (26 CFR § 1.36B-2(c)(3)(i)).

An eligible employer-sponsored plan is “affordable” if the portion of the annual premium that the employee or related individuals must pay for self-only coverage does not exceed the required contribution. The required contribution percentage is 9.69% of the employee's household income for 2017 (26 CFR § 1.36B-2(c)(3)(v), 26 CFR § 1.36B-2T, IRS Rev. Proc. 2016-24).

## Medicaid Managed Care Plans

Generally, with regard to enrollment in a Medicaid Managed Care plan, Medicaid recipients, except for those who are eligible for an exemption or an exclusion, must enroll in a Medicaid Managed Care plan (18 NYCRR § 360-10.4(a)).

A person who has primary medical or health care coverage available from or under a third-party health insurance provider whose premium amount is cost-effective as determined by the local department of social services is not eligible to enroll into a Medicaid Managed Care plan (NY Soc. Serv. Law § 364-j(3)(e)(xx), see Medicaid Managed Care Model Contract, section 6, 8, & Appendix H).

## **Legal Analysis**

The issue is whether NYSOH properly determined that your children were not eligible to enroll in a Medicaid Managed Care plan as stated in the January 7, 2017 eligibility determination notice.

In the relevant portion of the eligibility determination notice issued on January 7, 2017, NYSOH determined that your children remained eligible for Medicaid, effective January 1, 2017. This was because the household income of \$40,301.00 was at or below the allowable income limit of \$43,798.00 for a five-person household. The notice further stated that the type of Medicaid the children were eligible for did not require or allow you to enroll them in a health plan.

An employee or related individuals to the employee, who are eligible to enroll in an employer-sponsored health insurance plan that is affordable and provides minimum value, is/are not eligible to enroll in a Medicaid Managed Care plan through NYSOH.

According to your NYSOH account and your testimony, your children are eligible for enrollment in employer-sponsored insurance through your employer. You testified that the insurance through your employer for your children would be unaffordable to you. Employer-sponsored health insurance coverage is considered to be affordable if it costs no more than 9.69% of the household income. NYSOH uses the amount you would pay for self-only coverage through your employer to calculate whether or not a plan is affordable.

The application that was filed on January 6, 2017 listed an annual household income of \$40,301.01. You testified that this amount was correct at the time you filed your application.

Therefore, your employer sponsored health insurance coverage would be unaffordable to you if the premium cost associated with the self-only plan cost more than \$3,905.17 per year ( $\$40,301.01 \times 9.69\%$ ).

You provided documentation that, if you enrolled in a self-only plan through your employer, you would pay a semi-monthly cost of \$40.10. This results in an annual cost of \$962.40 ( $\$40.10 \times 2$  for semi-monthly  $\times 12$  months). Since your annual cost for a self-only plan through your employer is less than \$3,905.17, it is considered affordable by NYSOH.

Since your children are eligible to enroll in employer-sponsored health insurance and the cost for a self-only health plan through your employer costs less than 9.69% of your household income and there is no indication in the record that the available coverage does not provide minimum value to your children, the January 7, 2017 eligibility determination is correct and is AFFIRMED.

## **Decision**

The January 7, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** June 12, 2017

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

Your children are not eligible to enroll in a Medicaid Managed Care plan through NYSOH.

Your children were eligible for Medicaid Fee-For-Service as of January 1, 2017.

## **If You Disagree with this Decision (Appeal Rights)**

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 7, 2017 eligibility determination notice is AFFIRMED.

Your children are not eligible to enroll in a Medicaid Managed Care plan through NYSOH.

Your children were eligible for Medicaid Fee-For-Service as of January 1, 2017.

### **Legal Authority**

We are issuing this determination 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 مجاناً.

### বাংলা (Bengali)

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).

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।

### **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&btumi 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.

### **שׂוּדִישׁ (Yiddish)**

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).

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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