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

Notice of Decision

Decision Date: November 17, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000019799

[redacted]

[redacted]

On September 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 25, 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.

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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).

STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: November 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019799

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NYSOH properly determine that your child was eligible to enroll in full price Child Health Plus plan, effective March 1, 2017?
>
> Did NYSOH properly determine that your child was not eligible for Medicaid, effective March 1, 2017?

Procedural History

According to your NYSOH account, on April 21, 2017, pursuant to NYSOH's request, you submitted an Employee Payroll History as proof income, that was subsequently validated by NYSOH on April 24, 2017 (*see* Document [redacted]

On April 25, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible to enroll in full price Child Health Plus plan with a $183.18 monthly premium, effective March 1, 2017. The notice further stated that she was not eligible for Medicaid because your household income of $83,032.19 was over the allowable limit for that program.

On June 16, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your child was eligible for a full price Child Health Plus plan, and not eligible for Medicaid.

On September 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 October 4, 2017, to allow you to submit supporting documents.

As of October 4, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim one dependent on that tax return.

2) You are seeking insurance for your child. At the time of your application, your child was a [redacted] infant.

3) The application that was submitted on April 24, 2017, listed annual household income of $83,032.19, consisting of $83,032.19 you earn from your employment. You testified that this amount was incorrect because you are working less hours now, you did not work at all in the months of March 2017 through May 2017, and you went to per diem hours after your child was born.

4) According to your Employee History Report you submitted, you did receive income in both March 2017 and April 2017 in the form of paid time off and/or sick time ([redacted] [redacted]). You testified that this is correct.

5) According to that same report, between January 1, 2017 and April 6, 2017 you received in earned income from your employment at least $11,642.16. The report is missing several weeks of employment from January 1, 2017 through April 6, 2017 and does not show if this amount is your total gross year to date income (*id*).

6) According to your NYSOH Account, federal and state data sources reflect that you were also receiving [redacted] income from April 1, 2017 through June 30, 2017.

7) You testified that you expect your income to decrease this year because you are currently working three eight hour shifts per month at a rate of $26.80 per hour. This calculates to $864.00 per month. You further

testified that you are able to support your family because you have a substantial savings from when you worked full time.

8) Your application states that you will not be taking any deductions on your 2017 tax return. You testified this is incorrect and that your spouse has tuition and fees expenses in the amount of $3,100.00.

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

10) You testified that you would like your child to be eligible for Medicaid, and not Child Health Plus so that you can be reimbursed for your child's health plan premiums.

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

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Tuition and Fee Deductions

Subject to some limitations, tuition and fees for a dependent's higher education paid by the tax payer to a qualified educational institution can be deducted from adjusted gross income in an amount up to $4,000.00, provided the tax payer's yearly income does not exceed $80,000.00 for a single individual or $160,000.00 if married filing jointly. This deduction was renewed by Congress in December

2014 and made retroactive to the 2014 tax year and extended to December 31, 2017 (26 USC § 222(e); *see* IRS Publication 970).

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)).

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 $20,160.00 for a three-person household (81 Federal Register 4036).

Medicaid for Children

A child who is under one year of age 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 223% 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 was $20,420.00 for a three-person household (82 Federal Register 8831).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child was eligible to enroll in full price Child Health Plus plan, effective March 1, 2017.

On April 24, 2017, NYSOH validated your Employee Payroll History as satisfactory documentation of your income and an application for financial assistance was run on your behalf by an NYSOH representative. The NYSOH representative entered into your application an earned income of $27,540.00, and an additional income of $55,492.19. This resulted in an annual household income of $83,032.19. You testified that this amount was incorrect because you are working less hours in that you went to per diem hours after your child was born.

You testified that you are currently working three eight hour shifts per month at a rate of $26.80 per hour. This calculates to $864.00 per month. You further testified that you are able to support your family because you have a substantial savings from when you worked full time.

Additionally, you testified that your spouse has tuition and fees expenses in the amount of $3,100.00 that you would like considered when calculating your annual household income.

However, based on your Employee Payroll History, and your testimony, your expected household income for 2017 is not ascertainable. Although your Employee Payroll History reflects that between January 1, 2017 and April 6, 2017 you received in earned income from your employment at least $11,642.16, it does not show whether or not this amount is your total gross year to date. Moreover, you testified that you worked full time hours before your child was born, which conflicts with this report as it is missing several weeks of employment from January 1, 2017 through April 6, 2017.

As such, the Hearing Officer left the record open to allow you time to submit additional proof of household income and proof of your spouse's tuition and fees expenses. You did not provide any of the proof requested, and therefore this decision must be based on the evidence in the record, which reflects an annual expected income of $83,032.19 for 2017.

According to your NYSOH account and your testimony, you expect to file your 2017 income taxes as married filing jointly and will claim one dependent on that tax return. Therefore, for purposes of these analyses, your child is in a three-person household.

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 above 400% of the FPL are not eligible for a subsidy and are, thus, responsible for the full price Child Health Plus premium payment. On the date of your application, the relevant FPL was $20,160.00 for a three-person household. Since $83,032.19 is 411.87 % of the 2016 FPL, NYSOH properly found your child to be eligible for a full price Child Health Plus plan.

The second issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid as of March 1, 2017.

Medicaid can be provided through NYSOH to children under the age of one year old who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 223% of the FPL for the applicable family size. Since $83,032.19 is 410.24% of the 2017 FPL for a three-person household, NYSOH properly found your child to be ineligible for Medicaid.

Since the April 25, 2017 eligibility determination notice properly stated that, based on the information in your application, your child was eligible for a full price Child Health Plus plan and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The April 25, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 17, 2017

How this Decision Affects Your Eligibility

Your child was eligible for a full price Child Health Plus plan as of March 1, 2017.

Your child was ineligible for Medicaid as of March 1, 2017.

This Decision has no effect any of your child’s subsequent eligibilities.

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 April 25, 2017 eligibility determination notice is AFFIRMED.

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).

Your child was eligible for a full price Child Health Plus plan as of March 1, 2017.

Your child was ineligible for Medicaid as of March 1, 2017.

This Decision has no effect any of your child's subsequent eligibilities.

Legal Authority

We are sending you this notice 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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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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