



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

Notice of Decision

Decision Date: November 9, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020660

[REDACTED]

[REDACTED]

On October 4, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 18, 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: November 9, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020660

[REDACTED]

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?

Did NY State of Health properly determine that your children were eligible for Child Health Plus?

Did NY State of Health properly determine that you and your children were not eligible for Medicaid?

Procedural History

According to your NY State of Health (NYSOH) account, on July 14, 2017, you updated your NYSOH account and, pursuant to NYSOH's request, submitted copies of your current bi-weekly paystubs, dated June 23, 2017 and July 7, 2017

[REDACTED]

On July 15, 2017, NYSOH issued a notice, based upon your July 14, 2017 application, stating that the income information in your application does not match what NYSOH received from state and federal data sources. You were directed to provide proof of household income by August 1, 2017 to confirm your and your children's eligibility for health insurance.

The documents submitted on July 14, 2017 were validated by NYSOH on July 17, 2017

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On July 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan and your children were eligible for Child Health Plus, both effective September 1, 2017. That notice further stated that you and your children were not eligible for Medicaid because your and your children's household income of \$33,838.61 was over the allowable income limit for that program.

On July 19, 2017, you spoke to NYSOH's Account Review Unit and appealed your and your children's ineligibility for Medicaid.

On July 20, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan and your children's enrollment in Child Health Plus, both effective September 1, 2017.

On August 8, 2017, you submitted your July 21, 2017 bi-weekly paystub [REDACTED]

On October 4, 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) According to your NYSOH account, you expect to file your 2017 taxes with a tax filing status of single. You will claim two dependents on that tax return.
- 2) You are seeking Medicaid for yourself and your children.
- 3) On July 14, 2017, you submitted copies of your two most current bi-weekly paystubs dated June 23, 2017 and July 7, 2017. These paystubs show your 2017 expected gross annual income is \$33,838.61 calculated by NYSOH by adding the two paystubs $\$1,553.91 + \$1,049.06 = \$2,602.97$, then dividing $\$2,602.97/2 = \$1,301.485$, then multiplying that number by 26 bi-weekly pay periods in 2017 = \$33,838.61 [REDACTED]
- 4) The application that was submitted on July 17, 2017 listed annual household income of \$33,838.61, consisting of \$33,838.61 you earn from your employment. You testified that this amount was incorrect.

- 5) You testified that your expected income has decreased because of a reduction in your hourly wage and your lack of overtime hours.
- 6) You testified, and provided documentation to show, that your gross monthly household income for July 2017 was \$2,059.06, consisting of \$2,059.06 you earned from your employment ([REDACTED] [REDACTED] This was calculated by adding your two bi-weekly paystubs dated July 7, 2017 and July 21, 2017, in the amounts of \$1,049.06 and \$990.00.
- 7) Your application states that you will not be taking any deductions on your 2017 tax return. You testified that this incorrect as you make student loan payments in the amount of \$100.00 per month. You believe that 70% of this payment is interest.
- 8) According to your NYSOH account and your testimony, you and your children live in Westchester County, New York.
- 9) You testified that you have bills including rent, cable, and car payments that you think should be deducted from your household income.

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

Applicable Law and Regulations

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

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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)).

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 20082012 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 2017 FPL, which was \$20,420.00 for a three-person household (82 Fed. Reg. 8831).

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)).

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 federal poverty

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level (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 \$20,420.00 for a three-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).

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 funds 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.

Legal Analysis

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

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

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The application that was submitted on July 17, 2017 listed annual household income of \$33,838.61, consisting of \$33,838.61 you earn from your employment and the eligibility determination relied upon that information. During the hearing, you testified that this amount was incorrect and that your expected income has decreased because of a reduction in your hourly wage and your lack of overtime hours.

However, at the time of your application, although you provided several other paystubs, NYSOH determined your income based on the two most current paystubs you provided, dated June 23, 2017 and July 7, 201, and determined that your 2017 expected gross annual income to be \$33,838.61.

You also asked that your current expenses, including rent, cable, and car payments, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, and car payments to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for financial assistance purposes. Therefore, NYSOH properly determined your annual household income to be \$33,838.61.

The Essential Plan is provided through NYSOH to individuals who meet the nonfinancial 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 \$20,160.00 for a three-person household. Since an annual household income of \$33,838.61 is 167.85% 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 July 18, 2017 eligibility determination notice properly stated in relevant part that you were eligible for the Essential Plan, effective September 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 children were eligible for Child Health Plus, effective September 1, 2017.

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 \$20,160.00 for a three-person household. Since \$33,838.61 is 167.85% of the 2016 FPL, and your children would have been ineligible for Medicaid based on that calculation, NYSOH properly found your children to be eligible for Child Health Plus.

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Since the July 18, 2017 eligibility determination notice properly stated in part that your children were eligible for Child Health Plus, effective September 1, 2017, based on the information in your NYSOH account at that time, it is correct and must be AFFIRMED as to your children.

The remaining issue under review is whether NYSOH properly determined that you and your children were not eligible for Medicaid.

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. On the date of your application, the relevant FPL was \$20,420.00 for a three-person household. Since \$33,838.61 is 165.71% of the 2017 FPL, NYSOH properly found you and your children to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted two consecutive bi-weekly paystubs that shows in July 2017 you received \$2,059.06 in earned income.

To be eligible for Medicaid, you and your children would need to meet the non-financial criteria and have an income no greater than 138% and 154% of the FPL, which is \$2,349.00 and \$2,621.00 per month, respectively.

Since the record now contains a more accurate representation of what your and your children's July 2017 monthly household income is, your case is RETURNED to NYSOH to redetermine your and your children's eligibility for financial assistance as persons residing in [REDACTED], who are members of a three-person household with a July 2017 monthly household income of \$2,059.06.

Decision

The July 18, 2017 eligibility determination notice is AFFIRMED as correct when made.

Your case is RETURNED to NYSOH to redetermine your and your children's eligibility for financial assistance as persons residing in [REDACTED]

who are members of a three-person household with a July 2017 monthly household income of \$2,059.06, and to notify you accordingly.

Effective Date of this Decision: November 9, 2017

How this Decision Affects Your Eligibility

While your and your children's eligibility for financial assistance was based on information available to NYSOH at that time and, therefore, was correct when made, your case is being sent back to NYSOH to redetermine your and your children's eligibility based on the evidence of your July 2017 household income and size as adduced at the hearing.

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 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).

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 July 18, 2017 eligibility determination notice is **AFFIRMED** as correct when made.

Your case is **RETURNED** to NYSOH to redetermine your and your children's eligibility for financial assistance as persons residing in Westchester County, NY, who are members of a three-person household with a July 2017 monthly household income of \$2,059.06.

While your and your children's eligibility for financial assistance was based on information available to NYSOH at that time and, therefore, was correct when made, your case is being sent back to NYSOH to redetermine your and your children's eligibility based on the evidence of your July 2017 household income and size as adduced at the hearing.

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&btumi ama wo obi a okyerε 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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