



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

## Notice of Decision

Decision Date: November 29, 2017

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000021539

[REDACTED]

[REDACTED]

On October 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 15, 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 at the top of this notice.

### Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 CFR § 155.545.

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## Decision

Decision Date: November 29, 2017

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000021539

[REDACTED]

## Issues

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

Did NY State of Health (NYSOH) properly determine that your children, [REDACTED] and [REDACTED], were each eligible to enroll in Child Health Plus with a \$9.00 per month premium, effective September 1, 2017?

Did NYSOH properly determine that your children were not eligible for Medicaid?

## Procedural History

On August 3, 2017, NYSOH received your initial application in which you sought health insurance for your children.

On August 4, 2017, NYSOH issued a notice stating that the information contained in your application did not match the information NYSOH received from state and federal data sources. You were requested to provide income documentation for your household by August 18, 2017 so that an eligibility determination could be issued.

On August 10, 2017, NYSOH received four earnings statements issued to you by your employer, [REDACTED] between July 14, 2017 and August 4, 2017. These documents were reviewed and verified as acceptable proof of income on August 14, 2017.

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On August 14, 2017, NYSOH redetermined your household's eligibility for health insurance.

On August 15, 2017, NYSOH issued an eligibility determination notice stating that each of your children were eligible for CHP with a monthly premium of \$9.00, effective September 1, 2017.

On August 17, 2017, NYSOH issued an enrollment notice confirming your selection of a CHP plan for your children as of August 16, 2017, with such coverage beginning effective September 1, 2017.

Also on August 17, 2017, you spoke with NYSOH's Account Review Unit and appealed that determination insofar as your children were eligible for coverage through CHP, and not eligible for Medicaid.

Finally, on August 17, 2017, NYSOH received a screenshot of Job Summary issued by ██████████ reflecting that effective as of April 2, 2017, your annual earning rate was \$32,032.00 based on an hourly rate \$15.40.

On September 7, 2017, NYSOH received an Associate Wage and Job Classification Information letter issued by ██████████ that effective September 3, 2017, your earning rate was raised from \$15.40 to \$15.65 per hour.

On October 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: (1) all earnings statements issued to you by ██████████ during August 2017, and (2) the last 4 earnings statements issued to you by ██████████. The record was to be closed at 5:00 p.m. on October 27, 2017, or upon the receipt of the above referenced documents, whichever occurred earlier.

That same day, you provided to NYSOH Appeals Unit through your NYSOH account four earnings statements issued to you by ██████████ between August 4, 2017 and August 25, 2017, and three additional earnings statements issued to you by ██████████ between October 6, 2017 and October 20, 2017.

Accordingly, the record was closed on October 24, 2017.

## Findings of Fact

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

- 1) You testified that you expect to file your 2017 tax return with a tax filing status of head of household. You will claim your three children as dependents on that tax return, including the two children seeking health insurance through NYSOH.
- 2) In response to your updated application submitted on August 3, 2017, NYSOH requested that you provide additional income documentation by August 18, 2017 so that your household's eligibility could be determined.
- 3) On August 10, 2017, NYSOH you provided to NYSOH four earnings statements issued to you by [REDACTED] reflecting that you received (1) \$614.46 on July 14, 2017, (2) \$893.66 on July 21, 2017, (3) \$738.82 on July 28, 2017, and (4) \$987.91 on August 4, 2017.
- 4) On August 14, 2017, NYSOH redetermined your household's eligibility for financial assistance based on a household income of \$42,053.05. As a result, each of your children were found eligible to enroll in CHP with a \$9.00 monthly premium, effective September 1, 2017.
- 5) You subsequently enrolled your children in a CHP plan, with such coverage beginning effective September 1, 2017.
- 6) On August 17, 2017, you provided to NYSOH an Associate Wage and Job Classification Information letter issued by [REDACTED] reflecting that effective September 3, 2017, your earning rate was raised from \$15.40 to \$15.65 per hour.
- 7) You testified that your eligibility redetermination issued on August 14, 2017 was based on erroneous information because it included overtime income you received during several [REDACTED]. You further testified that your eligibility should be determined on your regular earnings, rather than overtime income that you cannot rely upon.
- 8) At the time of your August 14, 2017 redetermination of eligibility, your children who were seeking health insurance through NYSOH were [REDACTED].
- 9) Your application states that you will not be taking any deductions on your 2017 tax return.
- 10) You live in [REDACTED]

- 11) You testified that you would like your children to be eligible for Medicaid, and not CHP.
- 12) On October 24, 2017, you provided to NYSOH Appeals Unit four earnings statements that you received during the month of your redetermination, reflecting that you had received (1) \$987.91 on August 4, 2017, (2) \$825.52 on August 11, 2017, (3) \$967.58 on August 18, 2017, and (4) \$616.00 on August 25, 2017.
- 13) On October 24, 2017, you provided to NYSOH Appeals Unit three additional earning statements reflecting that you received (1) \$824.36 on October 6, 2017, (2) \$623.34 on October 13, 2017, (3) \$631.01 on October 20, 2017.

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

## **Applicable Law and Regulations**

### 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)).

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 \$24,300.00 for a four-person household (81 Federal Register 4036).

### 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 \$24,600.00 for a four-person household (82 Fed. Reg. 8831).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that your children were each eligible to enroll in CHP with a \$9.00 per month premium, effective September 1, 2017.

Each of your children are in a four-person household. You expect to file your 2017 income taxes as head of household and will claim three dependents on that tax return, including your two children seeking health insurance through NYSOH.

The record reflects that on August 4, 2017, NYSOH issued a notice stating that the information contained in your August 3, 2017 application did not match what NYSOH received from state and federal data sources. You were requested to provide income documentation for your household by August 18, 2017 so that an eligibility determination could be issued.

In response to this request, on August 10, 2017, you provided to NYSOH four earnings statements issued to you by ██████████ reflecting that you received (1) \$614.46 on July 14, 2017, (2) \$893.66 on July 21, 2017, (3) \$738.82 on July 28, 2017, and (4) \$987.91 on August 4, 2017.

These documents were reviewed by NYSOH on August 14, 2017 and verified as acceptable documentation to redetermine your household's eligibility for health insurance.

On August 14, 2017, NYSOH redetermined your household's eligibility based on an annual household income of \$42,053.05, which was in turn based on an average weekly income of \$808.71 *times* 52 weeks. The application also stated that your children were [REDACTED], respectively. NYSOH relied upon this information.

You testified that you did not believe your overtime income should be counted toward your overall income since you could not rely upon it; however, there is no exception for overtime in computing your annual household income when receiving overtime since it is required to be included to your modified adjusted gross income to determine your household's eligibility.

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 CHP premium payment. On the date of your application, the relevant FPL was \$24,300.00 for a four-person household. Since \$42,053.05 is 173.06% of the 2016 FPL, NYSOH properly found each of your children to be eligible for CHP with a \$9.00 per month premium payment.

The second 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. Since \$42,053.05 is 170.95% of the 2017 FPL for a four-person household, NYSOH properly found your child to be not eligible for Medicaid.

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

On October 24, 2017, at the request of the Hearing Officer, you provided to NYSOH Appeals Unit four earnings statements reflecting that you had received (1) \$987.91 on August 4, 2017, (2) \$825.52 on August 11, 2017, (3) \$967.58 on August 18, 2017, and (4) \$616.00 on August 25, 2017.

To be eligible for Medicaid, your children would need to meet the non-financial criteria and have an income no greater than 154% of the FPL, which is \$3,157.00

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per month. Since the documentation you provided shows that you earned \$3,397.01 during August 2017, your children do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the August 15, 2017 eligibility determination properly stated that, based on the information you provided, your children were each eligible for CHP with a \$9.00 per month premium and ineligible for Medicaid, it is correct and is AFFIRMED.

## **Decision**

The August 15, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** November 29, 2017

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

Your children remain eligible for CHP with a \$9.00 per month premium, effective September 1, 2017.

Your children are not eligible for Medicaid at this time.

## **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:

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).

- 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 August 15, 2017 eligibility determination notice is AFFIRMED.

Your children remain eligible for CHP with a \$9.00 per month premium, effective September 1, 2017.

Your children are not eligible for Medicaid at this time.

### **Legal Authority**

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**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 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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