STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: January 3, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000022747

[redacted]

On November 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 1, 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
  PO 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(b).

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 Date: January 3, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022747

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Issues

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

> Did NY State of Health (NYSOH) properly determine you were conditionally eligible for the Essential Plan with a $20.00 monthly premium, effective November 1, 2017?
>
> Did NYSOH properly determined your oldest child was eligible for Child Health Plus with a $9.00 monthly premium, effective November 1, 2017?
>
> Did NYSOH properly determine that you and your oldest child were not eligible for Medicaid?

Procedural History

On September 22, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on behalf of you and your oldest child. That day, a preliminary eligibility determination was prepared, stating you were conditionally eligible for the Essential Plan with a $20.00 monthly premium and your child was eligible for Child Health Plus with a $9.00 monthly premium.

Also on September 22, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you and your child were no longer eligible for Medicaid.

On October 1, 2017, NYSOH issued a notice of eligibility determination, based on the September 22, 2017 application, stating you were conditionally eligible for the Essential Plan with a $20.00 monthly premium, effective November 1, 2017.

You were directed to submit proof of your income to confirm your eligibility by December 21, 2017. Your child was eligible for Child Health Plus with a $9.00 monthly premium, also effective November 1, 2017. The notice indicated that you and your child were not eligible for Medicaid, because your household income was over the allowable income limits for that program.

On September 30, 2017, NYSOH issued an eligibility determination notice stating you and your child were eligible for Medicaid, for a limited time, effective November 1, 2017, until a decision was made on your appeal. You and your child were subsequently reenrolled into Medicaid Managed Care plans, effective November 1, 2017.

On November 16, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing; however, the call was disconnected midway through the hearing, while the Hearing Officer was describing the income documentation required to review eligibility for you and your child. The Hearing Office tried several times to contact you to finish the hearing, but was unable to reach you. Therefore, this decision is based on the record as developed during the hearing, prior to the call being disconnected.

Findings of Fact

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

1) An updated application was submitted on behalf of you and your oldest child on September 22, 2017. It listed your annual income as $27,000.00 consisting of $480.00 you attested to earning weekly at your full-time job with [redacted] and $170.00 you attested to earning monthly at your part time job with [redacted].

2) You testified you are only appealing eligibility for you and your oldest child.

3) According to your account, your youngest child was born on [redacted] and added to your account on November 3, 2016.

4) All applications submitted on your behalf, including the September 22, 2017 application, indicate you will claim only your oldest child as a dependent on your tax return.

5) At the hearing, you testified you intend to claim both your children as dependents on your 2017 tax return.

6) You testified you are unsure of your annual income amount.

7) You testified that the income information listed in the September 22, 2017 application for your full-time job was accurate, but that you had only worked at that job since April 2017. The hearing officer directed you to submit proof of income from that job.

8) You testified that you also worked at your part-time job every other weekend until October 2017.

9) The Hearing Officer directed you to submit proof of your income from your second job, specifically proof of the end date of that employment and the gross year to date income earned at that job. The call was disconnected at that point and the Hearing Officer was unable to obtain any further testimony from you.

10) NYSOH determined you conditionally eligible for the Essential Plan with a $20.00 monthly premium, effective November 1, 2017.

11) Because NYSOH could not verify the income information in your September 22, 2017 application, you were directed to submit proof of your income by December 21, 2017 to confirm your eligibility.

12) As of the date of this decision, NYSOH has not received documentation of your income in 2017.

13) Your child was determined eligible for Child health Plus with a $9.00 monthly premium.

14) You appealed insofar as you and your child were no longer eligible for Medicaid.

15) You and your child were granted aid to continue in your Medicaid Managed Care plans pending the decision in your appeal.

16) Your application indicates you will not be taking any deductions on your 2017 tax return.

17) Your application states that you live in Bronx County.

18) According to your account, your oldest child was [redacted] at the time of the [redacted].

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

Applicable Law and Regulations

Essential Plan Eligibility

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 $16,020.00 for a two-person household (81 Federal Register 4036).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016; *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016, *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

Verification of Eligibility for the Essential Plan

NYSOH must verify the eligibility of an applicant for the Essential Plan consistent with the standards set in 45 CFR § 155.315 and § 155.320 (New York's Basic Health Plan Blueprint, pgs. 16-17, as approved January 2016; *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf; 42 CFR § 600.345(a)(2)).

An applicant is required to attest to their household's projected annual income. (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Medicaid Eligibility

Adults: 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)).

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 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 $16,240.00.00 for a two-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).

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 2017 FPL, which was $16,240.00 for a two-person household (80 Federal Register 3236, 3237).

Legal Analysis

The first issue is whether NYSOH properly determined you were conditionally eligible for the Essential Plan with a $20.00 monthly premium, effective November 1, 2017.

The application that was submitted on September 22, 2017 listed an annual household income of $27,000.00. Although NYSOH found you *conditionally* eligible for the Essential Plan with a $20.00 monthly premium based on the information in that application, according to your account NYSOH was unable to verify that income information with state and federal data sources and you were directed to submit documentation of your income to confirm your eligibility. At the hearing, you were questioned regarding the amount of income earned at both your jobs in 2017 and you were directed to submit proof of your income; however, the call was disconnected before the Hearing Officer could obtain your full testimony. Moreover, as of the date of this decision, no documentation of your income in 2017 has been received by NYSOH.

Given the lack of verifiable or documentary evidence of your income and the unreliability of your incomplete testimony, it is concluded that the record is insufficient to modify the information relied on in the determination of eligibility under review. Therefore, the following review is based on the information as attested to in your September 22, 2017 application.

That application, indicated that you would file your 2017 tax return with a tax filing status of head of household and would only claim your oldest child as a dependent on that tax return. NYSOH relied on this information. Thus, according to that application, you are in a two-person household.

Pursuant to the regulations, the Essential Plan is provided through NYSOH to individuals who meet the non-financial 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 $16,020.00 for a two-person household. Since an annual household income of $27,000.00 is 168.54% of the 2016 FPL, NYSOH properly found you eligible for the Essential Plan, for a limited time, pending documentation confirming your household income amount. Furthermore, you were properly assessed a $20.00 monthly premium, because your attested household income amount was between 150% and 200% of the FPL.

The second issue is whether NYSOH properly determined your child was eligible for Child Health Plus with a $9.00 monthly premium, effective November 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. Households with an income between 160% and 222% of the FPL are responsible for a $9.00 per month Child Health Plus premium payment. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $27,000.00 is 166.26% of the 2017 FPL, NYSOH properly found your child eligible for Child Health Plus with a $9.00 per month premium payment.

The third issue is whether NYSOH properly determined you and your child were no longer eligible for Medicaid, effective November 1, 2017.

Medicaid can be provided through NYSOH to applications who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the applicable FPL for adults between the ages of 19 and 65 and at or below 154% of the applicable FPL for children at least one year of age but younger than nineteen.

On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $27,000.00 is 166.26% of the 2017 FPL, NYSOH

properly found you and your child ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

It is noted that financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size. However, as discussed above there is insufficient evidence in the record of your household income. Thus, the Appeals Unit is unable to determine the eligibility of you and your child for Medicaid on a monthly income basis.

Since the October 1, 2017 eligibility determination properly stated that, based on the information you provided, you were conditionally eligible for the Essential Plan with a $20.00 monthly premium, your child was eligible for Child Health Plus with a $9.00 per month premium, and both you and your child were ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The October 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 3, 2018

How this Decision Affects Your Eligibility

You remain conditionally eligible for the Essential Plan with a $20.00 monthly premium.

You are still required to submit sufficient documentation of your household income to confirm your eligibility.

Your child remains eligible for Child Health Plus with a $9.00 monthly premium.

You and your child are not eligible for Medicaid, based on your September 22, 2017 application.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the

dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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
  PO Box 11729

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 1, 2017 eligibility determination notice is AFFIRMED.

You remain conditionally eligible for the Essential Plan with a $20.00 monthly premium.

You are still required to submit sufficient documentation of your household income to confirm your eligibility.

Your child remains eligible for Child Health Plus with a $9.00 monthly premium.

You and your child are not eligible for Medicaid, based on your September 22, 2017 application.

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 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 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.

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).