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

Notice of Decision

Decision Date: January 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023168

[redacted]

[redacted]

On December 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 5, 2017 eligibility determination and disenrollment notices.

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 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: January 10, 2018

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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 properly determine that your child's enrollment in a Child Health Plus plan terminated effective October 31, 2017?
>
> Did NY State of Health properly determine that your child was not eligible for Medicaid as of November 1, 2017?

Procedural History

On October 22, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that your child was eligible for Child Health Plus (CHP) at a cost of $60.00 per month, effective December 1, 2016.

Also on October 22, 2016, a plan enrollment notice was issued confirming your child's enrollment in a CHP plan as of November 1, 2016.

On October 5, 2017, NYSOH issued an eligibility determination notice, based on your child's October 4, 2017 renewal application, stating that your child was newly eligible to purchase a qualified health plan at full cost, effective November 1, 2017. This was because your child was eligible for the New York State Health Insurance Program (NYSHIP). The notice further stated that your child was not eligible for Medicaid because his household income was over the allowable limit for that program.

Also on October 5, 2017, NYSOH issued a disenrollment notice stating your child's coverage with his CHP plan would end on October 31, 2017.

Also on October 5, 2017, you spoke to NYSOH's Account Review Unit and appealed the disenrollment date of your child's CHP plan.

On October 18, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for CHP for a limited time, effective November 1, 2017. The notice stated that your child has been granted Aid to Continue until a decision is made on your appeal.

Also on October 18, 2017, a plan enrollment notice was issued confirming your child's enrollment in a CHP plan as of November 1, 2017.

On December 8, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The Hearing Officer granted your request to amend the appeal to include consideration of your child's eligibility for Medicaid and testimony was received. The record was developed during the hearing and held open to December 23, 2017, to allow you time to submit supporting documents.

On December 19, 2017, you uploaded a copy of three paystubs from two employers, dated May 25, 2016, October 19, 2016 and May 31, 2017, along with a copy of your 2016 federal and New York State (NYS) income tax returns. These documents were made part of the record as "Appellant's Exhibit A." No further documentation was received as of December 23, 2017 and the record closed that day.

Findings of Fact

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

1) According to your NYSOH account and your testimony, your child was determined eligible for and enrolled in CHP effective November 1, 2016.

2) Your child was disenrolled from his CHP plan as of October 31, 2017 because your child was eligible for coverage with NYSHIP.

3) You testified that you had started a new job and now have individual coverage through NYSHIP. You further testified that, although your child is eligible to enroll in NYSHIP, the cost of family coverage is approximately $4,000.00 extra per year, as opposed to $60.00 per month for CHP.

4) You testified that 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.

5) You testified that on the date of your October 4, 2017 application, your spouse was pregnant.

6) You are seeking health insurance for your child, who was [redacted] as of the date of your October 4, 2017 application.

7) The application that was submitted on October 4, 2017 listed annual household income of $62,034.97, consisting of $47,084.96 you earn from your employment and $30,900.00 your spouse receives in employment income less deductions of $15,950.00. You testified that this amount was incorrect because you believed your spouse will earn less income in 2017 and may have other deductions since she receives a 1099 at the end of the year.

8) On December 19, 2017, you uploaded a copy of three paystubs from two employers, dated May 25, 2016, October 19, 2016 and May 31, 2017, along with a copy of your 2016 income tax return. Your paystubs show that you work for [redacted] your base pay is $45,257.00; you received in 2017 retroactive income in the amount of $444.34; and received overtime pay for annuals of $24.00 as of May 17, 2017.

9) Your submitted 2016 federal income tax return shows that your spouse had a total self-employment income of $2,240.00 (in addition to her employment income) as a [redacted] and [redacted], after deducting a single business expense in the amount of $666.00 for business use of vehicle. Additionally, she took a deduction of one half of her self-employment social security tax in the amount of $317.00.

10) Your submitted 2016 NYS income tax return shows that in 2016 you took a $15,950.00 standard deduction off your adjusted gross income. There are no other deductions indicated in this tax return.

11) You testified that you are seeking CHP or Medicaid for your child because it is more cost-effective than purchasing a family policy through your employer, [redacted]

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

Applicable Law and Regulations

Child Health Plus

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 Public Health Law § 2511(2)(a)(iii)).

To be eligible for Child Health Plus, the child:

- Must be under 19 years of age;
- Must be a New York State Resident;
- Must not have other health insurance coverage; and
- Must not be eligible for, or enrolled in, Medicaid

(NY Public Health Law § 2511(2)(a)-(e)).

Additionally, the Child Health Plus Model Contract, Appendix C., Section 4.5 provides that a child whose parent or guardian is a public employee of the State or a public agency with access to NYSHIP coverage, for which the State or public agency pays all or part of the cost of the family health insurance coverage, will not be eligible to enroll in Child Health Plus.

Household Size – Medicaid

For purposes of Medicaid eligibility, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver (42 CFR § 435.603(b); State Plan Amendment (SPA) 13-0055- -MM3, as approved by the US Department of Health and Human Services, 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 finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). As such standard deductions and exemptions are not an allowable deduction in computing adjusted gross income.

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 federal poverty 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 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 $24,600.00 for a four-person household (82 Federal Register 8831).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child's enrollment in a CHP plan terminated effective October 31, 2017.

According to your NYSOH account and your testimony, your child was determined eligible for and enrolled in CHP effective November 1, 2016.

On October 5, 2017, NYSOH issued a disenrollment notice advising you that your child's coverage in his CHP plan would be terminated as of October 31, 2017, because your child was eligible for enrollment in NYSHIP.

In order for a child to enroll in CHP, they must meet certain eligibility criteria. One of those criteria is that the child cannot be eligible for other health insurance coverage for which the State or a public agency pays all or part of the family health insurance coverage.

Since you provided documentation and credibly testified that you are employed by [redacted] and your child is eligible to enroll in NYSHIP, he is not eligible to enroll in CHP, the October 5, 2017 disenrollment notice is correct and must be AFFIRMED.

The second issue under review is whether NYSOH properly determined that your child was not eligible for Medicaid as of November 1, 2017, which issue was added at the time of hearing.

You testified that 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. Generally, this would mean that your child is in a three-person household. However, you testified that on the date of your October 4, 2017 application, your spouse was pregnant.

When calculating family size for Medicaid purposes, the household size of either a pregnant woman or a person who is in the family of a pregnant woman includes not only the pregnant woman but also the number of children she expects to deliver. On the date of your NYSOH application, your wife was pregnant, but this information is not reflected on your application, which caused NYSOH to determine your child's eligibility using a three-person household rather than a four-person household. However, to accurately account for the actual household size of your child at the time of your October 4, 2017 application, for purposes of a Medicaid analysis in this Decision, your child is in a four-person household.

The application that was submitted on October 4, 2017, listed annual household income of $62,034.97, consisting of $47,084.96 you earn from your employment and $30,900.00 your spouse receives in employment income less deductions of $15,950.00. You testified that this amount was incorrect because you believed your spouse will earn less income in 2017 and may have other deductions since she receives a 1099 at the end of the year. As such, the Hearing Officer left the record open to December 23, 2017, to allow you time to submit supporting documents.

On December 23, 2017, you submitted income documentation that shows your gross household income before any deductions is correct. However, it is further noted that NYSOH determines an individual's eligibility based on the modified adjusted gross income as determined by the IRS. As such, your 2016 NYS income tax return, while it does reflect your standard deduction of $15,950.00, this amount is not an allowable deduction in computing adjusted gross income for purposes of financial assistance through NYSOH.

Although your annual household income could be higher based on the evidence you presented, your total income for 2017 is not ascertainable as you indicated a decrease in your spouse's income in 2017, but provided no proof of this. As such, for purposes of this analysis your household income is $62,034.97, as is attested to in your October 4, 2017 application.

The record reflects your child was [redacted] as of your October 4, 2017 application.

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, which has been corrected to reflect four people. The applicable FPL for a four-person household is $24,600.00. Since $62,034.97, rounded to $62,035.00, is 252.17% of the 2017 FPL for a four-person household, your child was not eligible for Medicaid.

The same outcome applies to a three-person household as calculated by NYSOH and stated in the October 5, 2017 eligibility determination notice. The

applicable FPL for a three-person household is $20,420.00. Since, $62,035.00 is 303.8% of the 2017 FPL for a three-person household, NYSOH properly determined that your child was not eligible for Medicaid.

Since the October 5, 2017 eligibility determination properly stated that, based on the information you provided, that your child was not eligible for Medicaid, it is correct and is AFFIRMED.

Decision

The October 5, 2017 eligibility determination and disenrollment notices are AFFIRMED.

Effective Date of this Decision: January 10, 2018

How this Decision Affects Your Eligibility

Your child is not eligible for CHP or Medicaid through NYSOH.

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 October 5, 2017 eligibility determination and disenrollment notices are AFFIRMED.

Your child is not eligible for CHP or Medicaid through NYSOH.

Legal Authority

We are issuing this determination 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)

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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 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.

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