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

Notice of Decision

Decision Date: February 08, 2018

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000023608

[redacted]

[redacted]

On December 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 30, 2017 eligibility determination.

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.

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

Procedural History

On August 29, 2017, NYSOH received your application for health insurance for your family.

On August 30, 2017, NYSOH issued an eligibility determination notice stating in part, that your child was eligible to enroll in Child Health Plus (CHP) with a $0.00 monthly premium, effective October 1, 2017. The notice further stated that she was not eligible for Medicaid because your income of $32,178.88 was over the allowable limit for that program.

Also on August 30, 2017, NYSOH issued an enrollment notice confirming your child's enrollment in her CHP plan with a $0.00 monthly premium, with a plan enrollment start date of October 1, 2017.

On September 15, 2017, NYSOH issued an enrollment notice confirming your child's enrollment in her CHP plan with a $0.00 monthly premium, with a plan enrollment start date of September 1, 2017.

On October 23, 2017, you spoke to NYSOH's Account Review Unit and appealed the August 30, 2017 eligibility determination insofar as your child was eligible for coverage through CHP, and not eligible for Medicaid and that her CHP plan did not cover dental braces.

On December 28, 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, your child was originally enrolled in a CHP plan with an October 1, 2017 start date due to a system defect. On September 15, 2017 NYSOH corrected the system defect and backdated your child's CHP plan start date to September 1, 2017. You testified that the start date of your child's CHP plan is not an issue on appeal.

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

3) The application that was submitted on August 29, 2017 listed annual household income of $32,178.88. Your income consisted in $141.00 in monthly in [redacted] ($1,692.00 annually) and $169.88 in bi-weekly [redacted] benefits ($4,416.88 annually). Your spouse's income was listed as $23,270.00 in wages received from employment at [redacted] and 8 weeks of unemployment insurance benefits at $350.00 a week ($2,800.00 total).

4) Based on these amounts you listed in your August 29, 2017 application, NYSOH calculated your family estimated yearly income as $32,178.88 ($1,692.00 + $4,416.88 + $23,270.00 + $2,800.00).

5) At the time of your August 29, 2017 application, your child was [redacted] old.

6) According to your NYSOH account and your testimony, you will not be taking any deductions on your 2017 tax return.

7) According to your NYSOH account and your testimony, your family lives in [redacted] New York.

8) You testified that when your child was in Medicaid she was covered for [redacted], but that the CHP plan does not cover [redacted].

9) You testified that you would like your child to be eligible for Medicaid.

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)).

Generally, gross income does not include "amounts received through accident or health insurance (or through an arrangement having the effect of accident or health insurance) for personal injuries or sickness (other than amounts received by an employee, to the extent such amounts (A) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (B) are paid by the employer)" (26 USC § 104(a)(3)). Gross income does not include amounts received under workers compensation acts as compensation for personal injuries or sickness (*see* 26 USC § 104(a)(3)(a)(1)).

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)).

In an analysis of CHP 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 Federal Register 8831).

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 2017 FPL, which is $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 CHP.

According to the record, you expect to file a joint federal income tax return for the 2017 tax year and claim your one child as a dependent. Therefore, your child is in a three-person household.

In your August 29, 2017 application, expected annual household income was listed as $32,178.88. The application also stated that your child is [redacted] NYSOH relied upon this information.

Initially, we must review whether NYSOH properly calculated your household income as $32,178.88. NYSOH bases its eligibility determination on modified adjusted gross income as defined in the federal tax code.

The record reflects that NYSOH included the following amounts in your family's expected yearly income: $1,692.00 in your [redacted] benefits, $4,416.88 in [redacted] benefits, your spouse's $23,270.00 in wages and $2,800.00 in [redacted] benefits. However, the IRS does not include in gross income calculations any amounts received under workers compensation benefits that are compensation for personal injuries or sickness. Therefore, your workers compensation benefits of $4,416.88 should not have been included in the calculation of your expected annual household income, and the correct amount of your household income in calculating your family's benefits should have been $27,762.00.

A child is eligible to enroll in CHP if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). On the date of your August 29, 2017 application, the relevant FPL was $20,420.00 for a three-person household. Since $27,762.00 is 135.95% of the 2017 FPL, NYSOH improperly found your child to be eligible for CHP.

The second issue is whether NYSOH properly determined that your child was 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 $27,762.00 is 135.95% of the 2017 FPL for a three-person household, NYSOH should have found your child eligible for Medicaid.

Since the August 30, 2017 eligibility determination notice was based on an incorrect calculation of your household income it is RESCINDED.

Similarly, the August 30, 2017 and the September 15, 2017 enrollment confirmation notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of August 29, 2017, using a three-person household for a family residing in Livingston County, with expected 2017 annual income of $27,762.00, and to notify you accordingly.

Decision

The August 30, 2017 eligibility determination notice was based on an incorrect calculation of your household income and is RESCINDED.

The August 30, 2017 and the September 15, 2017 enrollment confirmation notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of August 29, 2017, using a three-person household for a family residing in [redacted], with expected 2017 annual income of $27,762.00, and to notify you accordingly.

Effective Date of this Decision: February 08, 2018

How this Decision Affects Your Eligibility

NYSOH erred in calculating your household income on August 29, 2017 which resulted in your child being determined for CHP and your spouse determined eligible for the Essential Plan.

This is not a final determination on your family's eligibility.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of August 29, 2017, using a three-person household for a family residing in Livingston County, with expected 2017 annual income of $27,762.00, and to notify you accordingly.

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 case 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.

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).

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

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Summary

The August 30, 2017 eligibility determination notice was based on an incorrect calculation of your household income and is RESCINDED.

The August 30, 2017 and the September 15, 2017 enrollment confirmation notices are RESCINDED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of August 29, 2017, using a three-person household for a family residing in Livingston County, with expected 2017 annual income of $27,762.00, and to notify you accordingly.

NYSOH erred in calculating your household income on August 29, 2017 which resulted in your child being determined eligible for CHP and your spouse determined eligible for the Essential Plan.

This is not a final determination on your family's eligibility.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of August 29, 2017, using a three-person household for a family residing in Livingston County, with expected 2017 annual income of $27,762.00, and to notify you accordingly.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 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।

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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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई 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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