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

Notice of Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025333

[redacted]

Dear [redacted],

On February 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 2, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025333

[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 and your son were eligible for the Essential Plan with a $20.00 monthly premium, effective January 1, 2018?
>
> Did NY State of Health properly determine that your daughter was eligible to enroll in Child Health Plus with a $9.00 per month premium, effective January 1, 2018?
>
> Did NY State of Health properly determine that you, your son, and your daughter were not eligible for Medicaid?

Procedural History

On December 1, 2017, you applied for health insurance and financial assistance through NY State of Health (NYSOH).

On December 2, 2017, NYSOH issued an eligibility determination notice stating that you and your son were eligible for the Essential Plan with a $20.00 per month premium each, and your daughter was eligible for Child Health Plus with a $9.00 per month premium, effective January 1, 2018. The notice further stated that you, your son, and your daughter were not eligible for Medicaid because your income was over the allowable income limit for that program.

On December 5, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as you, your son, and your daughter were not eligible for Medicaid.

On December 20, 2017, NYSOH issued a notice stating that you, your son, and your daughter, were eligible for Medicaid for a limited time, effective January 1, 2018. This was because you, your son, and your daughter had been granted Aid to Continue pending the outcome of your appeal.

Also on December 20, 2017, NYSOH issued an enrollment confirmation notice stating that you, your son, and your daughter were enrolled in a Medicaid Managed Care plan, effective January 1, 2018.

On February 8, 2018, you had a telephone hearing with a Hearing Officer from the NYSOH Appeals Unit. The record was developed during the hearing and held open up to February 22, 2018, to allow you time to submit supporting documents.

On February 15, 2018, NYSOH received your supporting documents by fax. The documents were incorporated into the record as Appellant's Exhibit #1 and the record was closed.

Findings of Fact

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

1) You testified that you expect to file your tax return for 2018 with a tax filing status of head of household. You will claim your two children as dependents on that tax return.

2) You testified, and your December 1, 2017 application reflects, that you are self-employed.

3) The application that you submitted on December 1, 2017 listed annual household income of $33,000.00, consisting of your self-employment earnings.

4) At the time of your December 1, 2017 application, your son was [redacted] and a full-time student. Your daughter was [redacted].

5) Your application states that you will be deducting business expenses on your 2018 tax return but does not list how much those deductions are in the deductions section of the application.

6) Your application states that you live in Westchester County.

7) On February 15, 2018 you submitted a written statement of your living and business expenses for the month of December 2017 which included totals for rent, food, your son's allowance and car insurance that you believe should be deducted from your household income. However, that statement did not include any details about your December income.

8) You also submitted a copy of your 2017 IRS Form 1040, which reflects an annual adjusted gross income of $13,498.00 consisting entirely of Line 12 business income, minus the deductible portion of your self-employment tax.

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

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, p. 21, as approved January 2016; see https://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).

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 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, he or she 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 $20,160.00 for a three-person household (82 Fed. Reg. 8831).

Medicaid for 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)).

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).

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).

A child aged 19 or 20, whose primary residence is with their parents, 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 155% of the FPL for the applicable family size (NY Social Services Law § 366(1)(b)(7); 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).

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)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id*.).

Legal Analysis

The first issue under review is whether NYSOH properly determined you and your son were eligible for the Essential Plan, effective January 1, 2018.

You and your son are in a three-person household. You expect to file your 2018 income tax return as Head of Household and will claim two dependents, including your son, on that tax return. The eligibility determination dated December 2, 2017 relied upon that information.

The application that you submitted on December 1, 2017 listed an annual household income of $33,000.00.

The Essential Plan is generally 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 $20,420.00 for a three-person household. Since an annual household income of $33,000.00 is 161.60% of the 2017 FPL, NYSOH correctly found you and your son to be eligible for the Essential Plan.

The second issue under review is whether NYSOH properly determined that your daughter was eligible to enroll in Child Health Plus with a $9.00 per month premium.

According to the record, you expect to file a federal income tax return for the 2018 tax year and claim your two children, including your daughter, as dependents. Therefore, your daughter is in a three-person household.

In your December 1, 2017 application, you attested to an expected household income of $33,000.00. The application also stated that your daughter is [redacted]

A child is eligible to enroll in Child Health Plus if they meet the non-financial requirements, is not eligible for Medicaid, and has 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 $20,420.00 for a three-person household. Since $33,000.00 is 161.60% of the 2017 FPL, NYSOH properly found your daughter eligible for Child Health Plus with a $9.00 per month premium payment.

The third issue under review is whether NYSOH properly determined that you, your son, and your daughter were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size.

Medicaid can be provided through NYSOH to children aged nineteen or twenty whose primary residence is with a parent, who meet the non-financial requirements and have a household modified adjusted gross income that is up to 155% of the FPL for the applicable family size.

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 that is at or below 154% of the FPL for the applicable family size

On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Since $33,000.00 is 161.60% of the 2017 FPL, NYSOH properly found you, your son, and your daughter to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

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

After the hearing, the record was left open for 15 days to allow you time to submit documentation of your household's income for the month of December 2017. You submitted a written statement of your December 2017 expenses however it did not include the amount of income you received in December 2017 from your self-employment. Therefore, NYSOH Appeals Unit is unable to review your, your son, and your daughter's eligibility for Medicaid on a monthly basis.

Since the December 2, 2017 eligibility determination notice properly stated that, based on the information you provided, you and your son were eligible for the Essential Plan that your daughter was eligible for Child Health Plus with a $9.00 per month premium, and you, your son, and your daughter were ineligible for Medicaid, it was correct and is AFFIRMED.

However, based on your testimony and review of your 2017 IRS Form 1040, the gross income you are obligated to report on your applications to NYSOH should reflect your earnings minus the business expenses you are entitled to itemize on your IRS Schedule C. Your application currently does not contain any of your business deductions. Therefore, your case is RETURNED to NYSOH for a redetermination of your, your son's, and your daughter's eligibility based on a household of three people, residing in Westchester County, with a projected 2018 household income of $13,498.00, which is the adjusted gross income that was reported on your 2017 income tax return

Decision

The December 2, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH for a redetermination of your, your son, and your daughter's eligibility based on a household of three people, residing in Westchester County, with an expected 2018 household income of $13,498.00.

Effective Date of this Decision: March 14, 2018

How this Decision Affects Your Eligibility

You and your son were properly determined eligible for the Essential Plan based on the information contained in your application.

Your daughter was properly determined eligible for Child Health Plus with a $9.00 per month premium based on the information contained in your application.

This is not a final determination of your, your son, and your daughter's eligibility. Your case is being sent back to NYSOH to redetermine your household's eligibility based on information you provided during your hearing.

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.

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 December 2, 2017 eligibility determination notice is AFFIRMED.

You and your son were properly determined eligible for the Essential Plan based on the information contained in your application.

Your daughter was properly determined eligible for Child Health Plus with a $9.00 per month premium based on the information contained in your application.

This is not a final determination of your, your son, and your daughter's eligibility. Your case is being sent back to NYSOH to redetermine your household's eligibility based on information you provided during your 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:

[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 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.

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).