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

Notice of Decision

Decision Date: March 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027114

[redacted]

Dear [redacted],

On March 9, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's failure to determine you and your child eligible for the Essential Plan.

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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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027114

[redacted]

Issues

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

> Did NY State of Health (NYSOH) fail to determine you eligible for the Essential Plan as of January 11, 2018?
>
> Did NYSOH fail to determine your child eligible for the Essential Plan as of January 11, 2018?

Procedural History

On January 11, 2018, three activities took place in your NYSOH account:

(1) A Financial Assistance application was submitted through NYSOH. Based on that application, NYSOH rendered a preliminary eligibility determination that you were determined eligible for Medicaid, and your child was determined eligible for Child Health Plus, with monthly premium of $0.00;
(2) A Non-Financial Assistance application was submitted through NYSOH. Based on that application, NYSOH rendered a preliminary eligibility determination that you and your child were eligible to enroll in a qualified health plan (QHP);
(3) You spoke with NYSOH's Account Review Unit and requested an appeal relative to you and your child not being eligible for the Essential Plan.

On January 12, 2018, NYSOH issued three notices:

(1) A plan enrollment notice confirming that as of January 11, 2018, you were enrolled in a Medicaid Managed Care (MMC) plan, and your child was enrolled in a Child Health Plus plan;
(2) An eligibility determination notice stating that you and your child were newly eligible to purchase a QHP at full cost, effective as of February 1, 2018;
(3) A disenrollment notice stating that that your MMC plan and your child's Child Health Plus plan would end as of January 31, 2018.

On January 18, 2018, NYSOH issued a plan enrollment notice confirming that as of January 17, 2018, you and your child were enrolled in a QHP with an enrollment start date of March 1, 2018.

On March 9, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until March 9, 2018, to allow you to submit income documentation for the month of January 2018.

On March 9, 2018, you faxed five-pages of documentation to NYSOH's Appeals Unit. That documentation was made part of the record as "Appellant Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) You testified that you want you and your child to be determined eligible to enroll in the Essential Plan.

2) According to your NYSOH account and testimony, your child was born on [redacted].

3) According to your NYSOH account and testimony, you expect to file your 2018 federal income tax return with a tax filing status of Head of Household (with qualifying individual), and expect to claim your child as a dependent on that tax return.

4) You testified that you are currently employed at [redacted], and that is your only source of income.

5) According to your NYSOH account and testimony, you are pregnant with a due date of [redacted].

6) On March 9, 2018, you submitted four earnings statements for the month of January 2018 to NYSOH's Appeals Unit. You were issued federal taxable wages of:

    (a) $600.00 on January 5, 2018;
    (b) $600.00 on January 12, 2018;
    (c) $600.00 on January 19, 2018;
    (d) $770.00 on January 26, 2018

    (Appellant Exhibit A [redacted]).

7) According to your NYSOH account, you do not expect to claim any deductions on your 2018 federal income tax return.

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

Applicable Law and Regulations

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

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)).

Medicaid – Pregnant Women

Generally, a tax dependent's household is the same as the household of the taxpayer who is claiming them as a tax dependent (42 CFR § 435.603(f)(2)).

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).

Medicaid is available to pregnant women who have a modified adjusted gross income at or below 223% of the FPL for the applicable family size (see 42 CFR § 435.116(c); New York State Department of Health 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). For the month of January 2018, that was the 2018 FPL, which is $20,780.00 for a three-person household (83 Fed. Reg. 2642).

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 by the US Department of Health and Human Services, March 19, 2014).

Child Health Plus - Eligibility

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

(N.Y. Pub. Health Law. § 2511(2)(a)-(e)).

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 and under 65 years of age, (2) expects to have a household income that exceeds 138% and at or below 200% of the applicable federal poverty level (FPL) (3) who is ineligible for Medicaid or Child Health Plus (4) is not otherwise eligible for minimum essential coverage except through the individual market, (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).

Legal Analysis

The first issue under review is whether NYSOH failed to determine you eligible to enroll in the Essential Plan as of January 11, 2018.

You testified that you are appealing the fact that you and your child were not determined eligible to enroll in the Essential Plan. The record does not contain a notice of eligibility determination regarding the issue of your and your child's eligibilities to enroll in the Essential Plan.

The lack of a notice of eligibility determination on the issue of your household's eligible for the Essential Plan does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH's failure to timely issue a notice of eligibility determination.

Your testimony regarding the relief that you are seeking permits an inference that NYSOH did determine you and your child ineligible for the Essential Plan. Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it been issued.

When determining an individual's eligibility for Medicaid, the household size of a pregnant woman includes not only the pregnant woman, but also the number of children she expects to deliver. The record reflects that you were pregnant during the month of [redacted]

Further, you expected to file your 2018 federal income tax return, with a tax filing status of Head of Household (with qualifying individual), and expected to claim your [redacted] child as a dependent on that tax return. Therefore, you were in a three-person household for purposes of this analysis.

Financial eligibility for Medicaid applicants is based on current monthly household income and family size. Medicaid can be provided to pregnant woman who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 223% of the FPL for the applicable family size, which is a monthly income of $3,862.00 for a three-person household.

On March 9, 2018, you submitted your four earnings statements for the month of January 2018 to NYSOH's Appeals Unit. You were issued federal taxable wages of: $600.00 on January 5, 2018; $600.00 on January 12, 2018; $600.00 on

January 19, 2018, and $770.00 on January 26, 2018 (Appellant Exhibit A pp. 2-5). Therefore, your monthly income was $2,570.00 and was within the allowable monthly income threshold to qualify for Medicaid.

Individuals who are eligible for Medicaid are ineligible to enroll in the Essential Plan. Since you were properly determined eligible for Medicaid as of January 11, 2018, NYSOH did not fail to determine you eligible to enroll in the Essential Plan.

The second issue under review is whether NYSOH failed to determine your child eligible for the Essential Plan as of January 11, 2018.

Children who are under the age of 19, a resident of New York, and ineligible for Medicaid are eligible to enroll in Child Health Plus. Individuals who are eligible for Child Health Plus are ineligible to enroll in the Essential Plan.

The record reflects that as of January 11, 2018, your [redacted] child met the non-financial criteria to be eligible for Child Health Plus. Since your child was eligible for Child Health Plus as of January 11, 2018, NYSOH did not fail to determine her eligible to enroll in the Essential Plan.

Decision

NYSOH did not fail to determine you were eligible to enroll in the Essential Plan.

NYSOH did not fail to determine your [redacted] child eligible to enroll in the Essential Plan.

Effective Date of this Decision: March 16, 2018

How this Decision Affects Your Eligibility

This decision does not change your or your child's eligibility for and enrollment in health insurance coverage 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.

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).

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

NYSOH did not fail to determine you were eligible to enroll in the Essential Plan.

NYSOH did not fail to determine your [redacted] child eligible to enroll in the Essential Plan.

This decision does not change your or your child's eligibility for and enrollment in health insurance coverage through NYSOH.

Legal Authority

We are sending you this notice in accordance with 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).

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).