



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

Notice of Decision

Decision Date: April 20, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027209

[REDACTED]

[REDACTED]

On March 15, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 7, 2018 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
Albany, NY 12211

Decision

Decision Date: April 20, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027209

[REDACTED]

Issues

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

Did NY State of Health properly calculate your household's modified adjusted gross income and household size when determining your family's eligibility for financial assistance?

Did NY State of Health properly determine that your youngest child was eligible for Child Health Plus with a \$9.00 monthly premium?

Did NY State of Health properly determine that you and your youngest child were not eligible for Medicaid?

Procedural History

On February 15, 2017, pursuant to NY State of Health's (NYSOH) request, you submitted 2017 benefit statements from the Social Security Administration, dated February 6, 2017, for yourself and your youngest child (child) (see Document [REDACTED])

On January 7, 2018, NYSOH issued an eligibility determination notice, based on your January 6, 2018 updated application, stating that your child was eligible for Child Health Plus (CHP) with a monthly premium of \$9.00, effective February 1, 2018. That notice also stated that he was not eligible for Medicaid because his annual household income was over the allowable income limit for that program.

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Also on January 7, 2018, NYSOH issued an eligibility determination notice stating you did not qualify for health coverage through NYSOH. This was because you have Medicare and the household income your annual household income was over the allowable income limit for Medicaid.

On January 15, 2018, you spoke to NYSOH's Account Review Unit and appealed these eligibility determination notices insofar as you and your child were not eligible for Medicaid.

On February 1, 2018, NYSOH issued an eligibility determination notice stating that your child was eligible for Medicaid through NYSOH for a limited time. Your child had been granted Aid to Continue until a decision is made on your appeal.

Also on February 1, 2018, a plan enrollment notice was issued confirming your child's enrollment in a Medicaid Managed Care plan as of February 1, 2018.

On March 15, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to March 30, 2018, to allow you time to submit supporting documents.

As of March 30, 2018, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

- 1) According to your NYSOH account, you will not be filing an income tax return and you have one dependent, your child, who resides with you.
- 2) You testified that you will not be filing a tax return for 2018 because you only receive Social Security Disability Income; however, you are single have two dependents that reside with you, both of whom are your two children.
- 3) You testified that your oldest child is no longer working and you plan on adding her as a dependent if you decide to file a tax return.
- 4) You are seeking Medicaid for yourself and your child. At the time of your and your child's application, he was [REDACTED].
- 5) The application that was submitted on January 6, 2018 listed annual household income of \$28,346.00, consisting of \$16,260.00 you receive in

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Social Security benefits and \$7,280.00 your child receives in employment income plus \$4,806.00 he receives in Social Security benefits. You testified that these amounts were incorrect.

- 6) You testified that you were unsure of your child's income because it varies paycheck to paycheck since he only works part time. You further testified that you do not know what his gross Social Security benefit is. You testified that your oldest child has not worked since [REDACTED] and is in the process of applying for unemployment.
- 7) You testified that, although you receive \$16,260.00 annually in Social Security benefit income, this is your net income. Your gross Social Security benefit income is \$1,489.00 per month, for a total of \$17,868.00 annually.
- 8) According to your NYSOH account, in January 2018, your child received \$801.00 in Social Security benefits, which totals \$9,612.00 annually. You are unsure what your child's employment income was for that month.
- 9) Your submitted documentation shows that in 2017 you received \$21,360.00 in Social Security benefits and your child received \$10,680.00 in Social Security benefits (see Document [REDACTED]).
- 10) You did not provide any further proof of income.

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)).

With regard to eligibility for financial assistance through NYSOH, a tax filer's household income includes the MAGI of all the individual's in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.46B-1(e)(1); 42 CFR § 435.603(d)(1)). The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

The IRS determines whether a dependent is required to file an income tax return based on the amount of the dependent's earned and unearned income, marital status, age and whether that dependent is blind. According to the latest final

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publication, in cases where the dependent is under the age of 65, not blind and earns an income \$6,350.00 or higher during the 2017 income tax year (or unearned income in the amount of \$1,050 or higher), that dependent is required to file an income tax return for 2017 (IRS Pub. 501).

Unearned income is generally all income other than salaries, wages and other amounts received as pay for work actually performed, including the taxable part of Social Security and pension payments (IRS Pub. 501).

For the purposes of determining a person's eligibility for financial assistance for health insurance through NYSOH, the term "MAGI" 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)).

Social Security Benefits Children

For the purposes of determining the amount of taxable income a person receives from Social Security benefits, the IRS gives the term "modified adjusted gross income" the same definition as "adjusted gross income," without regard to certain income that is not relevant here (26 USC § 86(b)(2)). This definition is different than the definition of MAGI that NYSOH uses.

A child's or tax dependent's income from Social Security benefits is included in their gross income only to the extent that the sum of the person's IRS-defined "modified adjusted gross income" and one half of their Social Security benefits is greater than \$25,000.00 (26 USC § 86(a)(1), (b)(1)), (c)(1)(A)).

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 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 child's application, that was the 2017 FPL, which was \$16,240.00 for a two-person household (82 Federal Register 8831).

Medicaid

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 was \$16,240.00 for a two-person household (82 Federal Register 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). On the date of your child's application, that was the 2017 FPL, which was \$16,240.00 for a two-person household (82 Federal Register 8831).

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Legal Analysis

The first issue under review is whether NYSOH properly calculated your household's modified adjusted gross income and household size when determining your family's eligibility for financial assistance.

You testified that the income and your household size was incorrect on your application. You testified that you are head of household and have two dependents that reside with you, both of whom are your children. You stated you will be adding your oldest child as a dependent on your tax return because she is no longer working.

You further testified that you were unsure of your other child's income because it varies paycheck to paycheck since he only works part time. You also testified that your oldest child has not worked since [REDACTED] and is in the process of applying for unemployment.

As such, the record was held open for you to provide proof of your household income and number of dependents. You did not submit this proof and, therefore, this decision must be based off the information in the record.

According to your NYSOH account, you will not be filing an income tax return and you have one dependent that resides with you, your child. Therefore, for purposes of this analysis, it is determined that you and your one child reside in a two-person household.

The application that was submitted on January 6, 2018, listed annual household income of \$28,346.00, consisting of \$16,260.00 you receive in Social Security benefits and \$7,280.00 your child receives in employment income plus \$4,806.00 he receives in Social Security benefits. NYSOH relied on this information.

You testified that although you receive \$16,260.00 annually in Social Security benefit income, this is your net income. Your gross Social Security benefit income is \$1,489.00 per month, which totals \$17,868.00 annually. Further, although you testified that you are unsure of what your child's gross Social Security benefit is, your application states that your child receives \$801.00 in Social Security benefit monthly, for a total of \$9,612.00 annually.

However, your submitted documentation shows that in 2017 you received \$21,360.00 in Social Security benefits and your child received \$10,680.00 in Social Security benefits (see Document [REDACTED]). Since this record is more credible than your testimony and the income information attested to in your application, it is determined that in 2017 you received \$21,360.00 in Social Security benefits and your child received \$10,680.00 in Social Security benefits

To determine the taxable amount of income a person receives from Social Security benefits, the IRS gives the term “modified adjusted gross income” the same definition as “adjusted gross income.”

You testified that you do not intend to file an income tax return for the 2017 tax year because you only receive income from Social Security benefits. Although you may not be required to file a tax return, you are not a child or a tax dependent, so your Social Security income, for purposes of eligibility for financial assistance through NYSOH, is still included in the household’s income. Therefore, your gross annual income for 2018 is expected to be at least \$21,360.00, based on your submitted documentation.

However, because your child was [REDACTED] at the time of his application, his modified adjusted gross income is determined based on the amount of his income that is taxable by the IRS.

According to the most recent IRS publication, a dependent is required to file a tax return when their earned income is greater than \$6,350.00. Your January 6, 2018 application states that your child expects to earn \$7,280.00 in employment income in 2018, therefore, NYSOH properly included your child’s employment income in your household’s income, based on the information you provided.

On the other hand, income from Social Security benefits, in cases of children and tax dependents, is included in their gross income only to the extent that the sum of the person’s IRS-defined “modified adjusted gross income” and one half of their Social Security benefits is greater than \$25,000.00. In determining your and your child’s eligibility for Medicaid, NYSOH included your child’s Social Security income as well as your own.

The record reflects that your child expects to receive a Social Security income of \$890.00 each month in 2018, including in January 2018.

The record reflects that your child’s expected income for 2018 is \$17,960.00, consisting of \$10,680.00 (\$890.00 x 12 months) from Social Security benefits plus his income from employment of \$7,280.00. Since, one half of that amount (\$8,980.00) is less than \$25,000.00, your child has no taxable income from Social Security and is not required to include his Social Security income on his income tax return.

Thus, for purposes of determining your and your child’s eligibility for Medicaid, your child’s Social Security benefit income in the amount of \$10,680.00 should be excluded. As such, it is determined that your household income is \$28,640.00, consisting of your Social Security benefit income of \$21,360.00 plus your child’s expected employment income of \$7,280.00.

The second issue under review is whether NYSOH properly determined that your child was eligible to enroll in CHP with a \$9.00 monthly premium.

As stated above, it is determined that your child resides in a two-person household and that your household income is expected to be \$28,640.00 in 2018.

At the time of your application, your child was [REDACTED].

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. Households with an income between 160% and 222% of the FPL are responsible for a \$9.00 per month CHP premium payment. On the date of your child's application, the relevant FPL was \$16,240.00 for a two-person household. Since \$28,640.00 is 176.35% of the 2017 FPL, NYSOH properly found your child to be eligible for CHP with a \$9.00 per month premium payment.

The third issue under review is whether NYSOH properly determined that you and your child were not eligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 and 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 138% of the FPL for an adult and 154% of the FPL for a child, respectively, for the applicable family size. On the date of your and your child's application, the relevant FPL was \$16,240.00 for a two-person household. Since \$28,640.00 is 176.35% of the 2017 FPL, NYSOH properly found you and your child to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Although, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size, you failed to provide any proof of your child's January 2018 monthly income. As such, these factors will not be considered.

Therefore, the January 7, 2018 eligibility determination notice, stating that your child is eligible for CHP with a \$9.00 monthly premium and your child is not eligible for Medicaid is correct and must be AFFIRMED.

Likewise, the January 7, 2018 eligibility determination stating that you do not qualify for health coverage through NYSOH because you are enrolled in Medicare and your annual household income was over the allowable income limit for Medicaid is also correct and must be AFFIRMED.

Decision

The January 7, 2018 eligibility determination notices are AFFIRMED.

Effective Date of this Decision: April 20, 2018

How this Decision Affects Your Eligibility

This decision does not change your or your child's eligibility.

Your child remains eligible for CHP with a \$9.00 monthly premium.

You and your child are not eligible for Medicaid.

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:

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).

- 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 January 7, 2018 eligibility determination notices are **AFFIRMED**.

This decision does not change your or your child's eligibility.

Your child remains eligible for CHP with a \$9.00 monthly premium.

You and your child are not eligible for Medicaid.

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:



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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye srε wo, frε 1-855-355-5777. ye&εtumi ama wo obi a okyerε kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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.