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

Notice of Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027906

[redacted]

[redacted]

On March 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 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 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).

This page intentionally left blank.

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

Decision

Decision Date: April 19, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000027906

[redacted]

Issues

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

> Did NYSOH properly determine that your youngest child was eligible to enroll in Child Health Plus with a $9.00 per month premium, effective March 1, 2018?
>
> Did NYSOH properly determine that your youngest child was not eligible for Medicaid?

Procedural History

On December 2, 2017, NY State of Health (NYSOH) issued a notice stating that it was time for you and members of your household to renew your health insurance coverage through NYSOH. This notice further stated that, based on state and federal data sources, NYSOH was unable to make a decision as to whether you and your household members would be eligible for help paying for your health insurance coverage. This notice directed you to update your NYSOH account between December 16, 2017 and January 18, 2018, so that NYSOH could make the appropriate decision.

On January 5, 2018, NYSOH received your updated application for financial assistance with health insurance.

On January 6, 2018, NYSOH issued an eligibility determination notice stating, in part, that your youngest child remained eligible for Medicaid, effective February 1, 2018. This notice further stated that you would receive a notice about

renewing your coverage around January 16, 2018, and that your youngest child's current coverage would end on February 28, 2018.

Also on January 6, 2018, NYSOH issued a plan enrollment notice confirming, in part, your youngest child's enrollment in his Medicaid Managed Care plan, effective November 1, 2017.

On January 17, 2018, an application for financial assistance with health insurance was submitted on your household's behalf.

On January 18, 2018, NYSOH issued an eligibility determination notice stating, in part, that your youngest child was eligible to enroll in a Child Health Plus plan with a $9.00 monthly premium, effective March 1, 2018. This notice further stated that your youngest child was no longer eligible for Medicaid through NYSOH as of February 28, 2018.

Also on January 18, 2018, NYSOH issued a plan enrollment notice confirming, in part, your youngest child's enrollment in a Child Health Plus plan with a $9.00 monthly premium, effective March 1, 2018.

On January 26, 2018, you spoke to NYSOH's Accounts Review Unit and appealed the January 18, 2018 determination insofar as your youngest child was eligible for coverage through Child Health Plus, and not eligible for Medicaid.

On March 21, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was left open until April 5, 2018, to allow you time to submit supporting income documentation.

On April 4, 2018, NYSOH's Appeals Unit 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) The application that was submitted on January 17, 2018, indicated that you expect to file your 2018 tax return with a tax filing status of head of household and that you will claim your two youngest children as dependents on that tax return.

2) The application that was submitted on January 17, 2018, listed an expected annual household income for 2018 of $32,760.00, consisting of income you earn from your employment.

3) You submitted income documentation that shows in the month of January 2018 you earned $2,538.48 in gross income (*see* [redacted]).

4) This income documentation also shows that you had a deduction from your biweekly income to a [redacted] account in the amount of $63.46 biweekly, or $126.92 per month [redacted].

5) After your retirement plan deductions [redacted] your taxable monthly income for January 2018 was $2,411.54.

6) Using the income documentation you provided, your household's expected annual income for 2018 is $31,350.02 ($32,999.98 you earn from your employment and a IRA deduction of $1,649.96).

7) At the time of your January 17, 2017 application, your youngest child was [redacted].

8) Your application states that you and your children live in [redacted], NY.

9) You testified that you would like your youngest child to be eligible for Medicaid, and not Child Health Plus.

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

Applicable Law and Regulations

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)).

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 2018 FPL, which is $20,780.00 for a three-person household (83 Fed. Reg. 2642).

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 be claimed as a tax dependent by another taxpayer for the taxable year in which an initial determination or renewal of eligibility is being made, the household is the household of the taxpayer claiming such individual as a tax dependent (42 CFR § 435.603(2)).

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 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 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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your youngest child was eligible to enroll in Child Health Plus with a $9.00 per month premium, effective March 1, 2018.

According to the January 17, 2018 application, you expect to file your 2018 federal tax return as head of household and you plan on claiming your two youngest children as dependents. Therefore, your child is in a three-person household for purposes of this analysis.

In the January 17, 2018 application, you attested to an expected household income of $32,760.00. The application also stated that your child is [redacted]. NYSOH relied upon this information.

A child is eligible to enroll in Child Health Plus 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 Child Health Plus premium payment. On the date of your application, the relevant FPL was $20,780.00 for a three-person household. Since $32,760.00 is 157.65% of the 2018 FPL, NYSOH properly found your child to be eligible for Child Health Plus with a $9.00 monthly premium, based on your expected annual household income as listed in the January 17, 2018 application.

The second issue under review 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 $32,760.00 is 157.65% of the 2018 FPL for a three-person household, NYSOH properly found your child to be not eligible for Medicaid, based on your expected annual household income as listed in the January 17, 2018 application.

Since the January 18, 2018 eligibility determination notice properly stated that, based on the expected annual income information provided in your application,

your youngest child was eligible for Child Health Plus with a $9.00 per month premium and ineligible for Medicaid, it is correct and is AFFIRMED.

However, NYSOH bases its eligibility determinations on modified adjusted gross income (MAGI) as defined in the federal tax code. The Internal Revenue Service (IRS) allows a tax payer to deduct from their adjusted gross income the amount of income that is deducted for payments to certain retirement funds.

The record indicates that on April 4, 2018, you submitted two biweekly paystubs to your NYSOH account (*see* [redacted]), which indicates that you have $63.46 deducted from your biweekly paystubs for payments into a [redacted]. Since a payment to a retirement account can be deducted on your tax return, based on IRS regulation, your household's eligibility should have been determined using a MAGI of $31,350.02 ($32,999.98 you earn from your employment and a IRA deduction of $1,649.96).

Since the record now contains a more accurate representation of your expected annual household income for 2018, your case is RETURNED to NYSOH to redetermine your youngest child's eligibility, as of the date of this decision, using a three-person household with an annual expected income of $31,350.02, in [redacted], NY, and to notify you accordingly.

Decision

The January 18, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your youngest child's eligibility, as of the date of this decision, using a three-person household in [redacted], NY, with an annual expected income of $31,350.02, and to notify you accordingly.

Effective Date of this Decision: April 19, 2018

How this Decision Affects Your Eligibility

NYSOH properly determined that your youngest child was eligible to enroll in a Child Health Plus plan with a $9.00 monthly premium and was not eligible for Medicaid, effective March 1, 2018, based on the annual expected income information provided in the January 17, 2018 application.

This is not a final determination of your youngest child's eligibility.

Your case is being sent back to NYSOH to redetermine your youngest child's eligibility based on the parameters noted above. NYSOH will notify you accordingly once this has been completed.

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:

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 1-855-355-5777
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The January 18, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your youngest child's eligibility, as of the date of this decision, using a three-person household in [redacted], NY, with an annual expected income of $31,350.02, and to notify you accordingly.

NYSOH properly determined that your youngest child was eligible to enroll in a Child Health Plus plan with a $9.00 monthly premium and was not eligible for Medicaid, effective March 1, 2018, based on the annual expected income information provided in the January 17, 2018 application.

This is not a final determination of your youngest child's eligibility.

Your case is being sent back to NYSOH to redetermine your youngest child's eligibility based on the parameters noted above. NYSOH will notify you accordingly once this has been completed.

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.

(Bengali)

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).

,

1-855-355-5777

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)

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).

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).