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

Notice of Decision

Decision Date: May 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028855

[redacted]

Dear [redacted]

On May 14, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 14, 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 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: May 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028855

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that your daughter was ineligible for Medicaid and Child Health Plus under your account?

Procedural History

On February 13, 2018, you submitted an application for financial assistance to NYSOH. That day, NYSOH prepared a preliminary eligibility determination with regard to that application stating that your daughter was eligible to purchase a qualified health plan at full cost through NYSOH, effective March 1, 2018.

Also on February 13, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar as your daughter was ineligible for financial assistance on this account.

On February 14, 2018, NYSOH issued a notice of eligibility determination stating that your daughter was eligible to purchase a qualified health plan at full cost through NYSOH, effective March 1, 2018. This notice also stated that your daughter was not eligible for Medicaid or Child Health Plus because she was qualified for coverage under another NYSOH account.

On May 14, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, Haitian Creole interpreter #[redacted] assisted with the hearing. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) You testified that your daughter was born on [redacted] and that she is [redacted]

2) You testified that your daughter has lived with you since her birth and has no visitation with her father.

3) You testified that you recently moved from [redacted] to New York State and that your daughter lived with you in [redacted].

4) You testified that you anticipate filing your 2018 tax return as head of household and you will claim one dependent, your daughter, on that tax return.

5) You testified that so far, you have been unable to claim your daughter as a dependent, as her father has claimed her each year since her birth. You testified that when you attempted to file your 2017 tax return, you tried to claim your daughter as a dependent, but were advised that your daughter's father had already filed his 2017 tax return and had claimed your daughter as a dependent.

6) You testified that you have no divorce settlement or custody agreement with regard to your daughter.

7) You testified that there is no legal document which governs whether you or your daughter's father may claim your daughter as a dependent or whether you or your daughter's father must provide health insurance for your daughter.

8) The application that you submitted on February 13, 2018 lists annual expected income for your household of $0.00. You testified that as of that time, this information was correct. You had recently moved to New York State, you were not yet working and you were living on your savings. You explained that in March 2018 you began working.

9) Your application states, and you confirmed, that you will not claim any deductions on your 2018 tax return.

10) Your application states, and you confirmed, that you reside in Queens County.

11) You testified that you have not yet filed for child support or legal custody of your daughter, as you must reside in New York State for a specified period of time prior to filing such an action.

12) You testified that your daughter's father filed an action regarding paternity of your daughter, alleging that he is not the child's father, however, he failed to appear for court, and there have been no findings or final determination on his action.

13) You testified that you are seeking for your daughter to be found eligible for Medicaid through your NYSOH account, removed from the other account she is listed on, and that you be permitted to claim your daughter as a dependent on your tax return.

14) On April 19, 2018, NYSOH uploaded an evidence packet ([redacted] to your NYSOH account. Under section eight, call record timeline, an entry from February 13, 2018 indicates that your daughter was ineligible for financial assistance due to individual duplicate coverage as your daughter had coverage on another account. The NYSOH system reflects your daughter has been found eligible for Medicaid under another account and is listed as being claimed as a dependent by another individual.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Household Composition for Children

In the case of an individual who expects to file a tax return, and who does not expect to be claimed as a tax dependent by another taxpayer, the household consists of the taxpayer and, subject to specific limitations, all persons whom such individual expects to claim as a tax dependent (42 CFR §435.603(f)(1)).

The household of an individual who expects to be claimed as a tax dependent by another taxpayer consists of the household of the taxpayer claiming the individual as a dependent, except that where a child expects to be claimed as a tax dependent by a non-custodial parent, the child's family includes the following persons, if living with the child: (1) the child's parents, (2) the child's spouse, (3) the child's children and siblings under the age of 19, or 21 if a full-time student (42 CFR § 435.603(f)(3)). For the purpose of determining a who is the custodial parent a court order or binding separation, divorce or custody agreement establishing physical custody controls or if there is no such order or agreement, the custodial parent is the parent with whom the child spends most nights.

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 federal poverty level (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 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 $16,460.00 for a two-person household and $20,780.00 for a three-person household (83 Fed. Reg. 2642).

Child Health Plus

A child who meets the eligibility requirements for Child Health Plus (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) (New York Public Health Law (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 Public Health Law § 2511(2)(b)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your daughter was ineligible for Child Health Plus and Medicaid under your account.

You testified that you expect to file your 2018 tax return with a tax filing status of head of household and you will claim your daughter as a dependent on that return.

On your February 13, 2018 application, you attested to an expected household income of $0.00. The application also stated that your daughter was [redacted].

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.

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.

However, the record reflects that your daughter already has been found eligible for Medicaid on another NYSOH account.

As your [redacted] child already has Medicaid, NYSOH properly found her ineligible for Medicaid on your account.

Under New York State's Public Health Law, a Medicaid-eligible child does not qualify to enroll in health insurance through Child Health Plus.

As the record reflects that your daughter already has Medicaid on another NYSOH account, NYSOH properly found your daughter ineligible for Child Health Plus.

Therefore, the February 14, 2018 eligibility determination notice is AFFIRMED.

You testified that there is no legal document which governs whether you or your daughter's father may claim your daughter as a dependent or whether you or your daughter's father must provide health insurance for your daughter.

As such, NYSOH Appeals Unit cannot direct that your child be removed from the other account on which she has coverage.

Additionally, NYSOH Appeals Unit only has the authority to review issues related to the following: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions, (3) an eligibility determination for an exemption, (4) a failure to provide timely notice of an eligibility determination and (5) a denial of a special enrollment period.

The NYSOH Appeals Unit is not given the authority to determine who may claim a child as a dependent.

Decision

The February 14, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 21, 2018

How this Decision Affects Your Eligibility

Your child remains eligible to purchase a qualified health plan at full cost through your account as she has coverage through another NYSOH account.

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:

- 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 February 14, 2018 eligibility determination notice is AFFIRMED.

Your child remains eligible to purchase a qualified health plan at full cost through this account as she has coverage through another NYSOH account.

Legal Authority

We are issuing this determination 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।

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Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

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

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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