

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

## Notice of Decision

Decision Date: November 16, 2017

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000021608

[REDACTED]

[REDACTED]

On October 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 18, 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 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).

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## Decision

Decision Date: November 16, 2017

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000021608

[REDACTED]

## Issues

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

Did NY State of Health (NYSOH) properly determine that your older daughter was eligible to enroll in Child Health Plus at full cost, effective September 1, 2017?

Did NYSOH properly determine that your younger daughter was eligible for Child Health Plus with a \$45.00 monthly premium, effective September 1, 2017?

## Procedural History

On June 19, 2017, NYSOH received an update to your application for health insurance.

On June 20, 2017, NYSOH issued an eligibility determination notice stating that each of your daughters remained eligible for Medicaid, effective August 1, 2017. The notice further stated that this current eligibility would end on August 31, 2017, and that you would get a notice about renewing their coverage around July 16, 2017.

On July 17, 2017, NYSOH redetermined your household's eligibility for health insurance.

On July 18, 2017, NYSOH issued an eligibility determination notice stating that your older daughter was eligible for Child Health Plus (CHP) at full cost. The

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same notice also stated that your younger daughter was eligible for CHP at a monthly premium of \$45.00. This eligibility determination was effective September 1, 2017.

On August 9, 2017, NYSOH issued an enrollment notice confirming your selection of a CHP plan for both of your daughters, with coverage effective September 1, 2017. The notice reflected that your older daughter's premium was \$139.93 per month, and your younger daughter's premium was \$45.00 per month, also effective September 1, 2017.

On August 18, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as you were seeking a review of your daughters' eligibility for CHP at their respective premium levels.

On October 24, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing 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 you expect to file your 2017 tax return with a tax filing status of head of household. You will claim your older daughter as a dependent on that tax return.
- 2) You testified that while your younger daughter lives with you, she is claimed by your ex-spouse on her tax return. You further testified that this was the dependent claiming arrangement between you and your ex-spouse pursuant to your divorce decree.
- 3) Your household's eligibility was redetermined on July 17, 2017, and listed annual household income of \$70,000.00, consisting solely of income you anticipate receiving from your employment with [REDACTED] during 2017. You testified that this amount was correct.
- 4) At the time of your July 17, 2017 redetermination, your daughters were [REDACTED] respectively.
- 5) Your application states that you will not be taking any deductions on your 2017 tax return.
- 6) You live in [REDACTED]

- 7) You testified that you were seeking a review of your children's eligibility for their respective CHP premiums to be reviewed, since you were surprised that your older daughter's CHP plan coverage was at full cost, while your younger daughter was found eligible for CHP plan coverage with a monthly premium of \$45.00.

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 \$45.00 per month for a child whose family household income is between 301% and 350% of the FPL, but no more than \$135.00 per month per family (NY PHL § 2510(9)(d)(v)).

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 application, that was the 2016 FPL, which was \$16,020.00 and \$20,160.00 for a two-person household and three-person household, respectively (81 Federal Register 4036).

## Household Composition

Generally, a child who is claimed as a tax dependent by their custodial parent has the same household size as the parent that is claiming them (42 CFR § 435.603(f)(2)).

In the case where a child is claimed 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)(2)(iii)).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that your older daughter was eligible to enroll in CHP at full cost, effective September 1, 2017.

For purposes of determining your children's eligibility for CHP, a determination of your children's family size is necessary.

Generally, a child who is claimed as a tax dependent by a custodial parent has the same household size as the parent that is claiming her. For your older daughter, her household size would be determined based on the same criteria as your own. Because you claim only her as your only dependent, her household size would be two: herself and you.

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 Federal Poverty Level (FPL). The CHP premium is \$45.00 per month for a child whose family household income is between 301% and 350% of the FPL.

The July 17, 2017 eligibility redetermination reflected, and you confirmed, that you had an expected household income of \$70,000.00. The application also stated that your daughters were [REDACTED]

Since \$70,000.00 is 436.95% of the 2016 FPL for a two-person household, NYSOH properly found your older daughter eligible for CHP coverage at full cost, effective September 1, 2017.

The second issue under review is whether NYSOH properly determined that your younger daughter was eligible for CHP with a \$45.00 monthly premium, effective September 1, 2017.

In the case where a child is claimed 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, and (3) the child's children and siblings under the age of 19, or 21 if a full-time student.

Since according to your divorce decree, your ex-spouse claims your younger daughter as a dependent, despite no longer residing within your ex-spouse's household, her household size is determined to include both the parent residing with her and her siblings residing with her. This would mean she would have a three-person household size.

Since \$70,000.00 is 347.22.95% of the 2016 FPL for a three-person household, NYSOH properly found your older daughter eligible for CHP coverage with a \$45.00 monthly premium, effective September 1, 2017.

Since the July 18, 2017 eligibility determination notice properly stated that, based on the information you provided, your older daughter was eligible for CHP plan coverage at full cost, and your younger daughter was eligible for CHP plan coverage at a monthly premium of \$45.00, it is correct and is AFFIRMED.

## **Decision**

The July 18, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** November 16, 2017

## **How this Decision Affects Your Eligibility**

Your daughter's eligibility has not changed.

Your older daughter remains eligible for CHP plan coverage at full cost.

Your younger daughter remains eligible for CHP plan coverage with a \$45.00 monthly premium.

## **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.

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).

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

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## **Summary**

The July 18, 2017 eligibility determination notice is AFFIRMED.

Your daughter's eligibility has not changed.

Your older daughter remains eligible for CHP plan coverage at full cost.

Your younger daughter remains eligible for CHP plan coverage with a \$45.00 monthly premium.

## **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:**



## **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।

## 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 sre wo, frɛ 1-855-355-5777. yɛbɛtumi ama wo obi a okyerɛ 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.