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

Notice of Decision

Decision Date: November 29, 2017

NY State of Health Number:
Appeal Identification Number: AP000000022357

On November 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 13, 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: November 29, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000022357

[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 child was eligible to enroll in Child Health Plus at full cost, effective October 1, 2017?

Procedural History

On September 11, 2017, NYSOH received your application for health insurance.

Also on September 11, 2017, NYSOH received four earning statements issued to you by your employer, [redacted] between July 27, 2017 and September 7, 2017.

On September 12, 2017, NYSOH issued a notice stating that the information contained in your application did not match what NYSOH received from state and federal data sources. You were requested to provide proof of your household income by September 12, 2017.

Also on September 12, 2017, NYSOH redetermined your household's eligibility for health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that your child was eligible for Child Health Plus (CHP) at full cost, effective October 1, 2017.

Finally, on September 12, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary determination insofar as your child was not found eligible for CHP at a reduced monthly premium.

On September 13, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible to enroll in CHP at full cost, effective October 1, 2017.

On November 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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 you expect to file your 2017 tax return with a tax filing status of married filing jointly. You will claim your child as a dependent on that tax return.

2) On September 11, 2017, you provided four earnings statements issued to you by your employer reflecting that you received $3,153.85 on July 27, 2017, August 10, 2017, August 24, 2017 and September 7, 2017. However, in each case, your federal taxable wages were reflected as $2,892.25 because of several pre-tax deductions including your dental insurance premium, medical insurance premium, and 401(k) contributions.

3) Your eligibility was redetermined on September 12, 2017 based on an annual household income of $82,000.11, consisting of $3,153.83 once every two weeks you received from your employer, [redacted] You testified that this amount was correct, although it did not did not include an adjustment for your 401K deduction or your health insurance premiums through your employer.

4) At the time of the September 12, 2017 redetermination, your child was [redacted].

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 would like your child to be eligible for CHP at a reduced cost since he was previously eligible for CHP with a $9.00 monthly premium.

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)).

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 federal taxable 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)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Retirement Savings

"Adjusted gross income" is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, deductions that are

attributable to retirement savings may be deductions from a taxpayer's adjusted gross income (26 USC § 62 (a)(7)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your child was eligible to enroll in Child Health Plus at full cost, effective October 1, 2017.

You expect to file your 2017 income taxes as married filing jointly and will claim your child as a dependent on that tax return. Therefore, for purposes of this, you are in a three-person household.

According to your NYSOH account, and your testimony, you live in [redacted] [redacted], New York.

Your household's eligibility was redetermined on September 12, 2017, listing an annual household income of $82,000.01, consisting solely of $3,153.85 you earn from your employment with [redacted]. once every two weeks. During the hearing, you testified that this is correct but did not include an adjustment for your 401K deduction or your health insurance premiums through your employer, which should be considered when determining your eligibility.

Because the Internal Revenue Service rules do allow certain expenses, such as your 401k deductions and medical and dental premiums, to be excluded from your income in determining your modified adjusted gross income, such expenses can be excluded from your income in determining your modified adjusted gross income for purposes of determining your eligibility for financial assistance through NYSOH.

When the 401k deduction and health insurance premium payments is deducted from your income, as corroborated by the four-current consecutive weekly paystubs dated July 27, 2017 through September 7, 2017 you submitted, your 2017 expected federal taxable gross income is $75,198.50.

Since your current income documentation reflects your calculated 2017 expected FTGI is $75,198.50, the September 13, 2017 eligibility determination notice is not supported by the record and must be RESCINDED.

As such, your case is RETURNED to NYSOH to redetermine your child's eligibility for financial assistance with health insurance as of September 12, 2017 and to apply it effective October 1, 2017, using a three-person household with an expected annual income of $75,198.50, for an individual living in Queens County, New York.

Decision

The September 13, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your child's eligibility for financial assistance with health insurance as of September 12, 2017 and to apply it effective October 1, 2017, using a three-person household with an expected annual income of $75,198.50, for an individual living in Queens County, New York.

Effective Date of this Decision: November 29, 2017

How this Decision Affects Your Eligibility

NYSOH improperly determined that your child was eligible for CHP at full cost as of the September 12, 2017 redetermination.

Your case is sent back to NYSOH to redetermine your child's eligibility for financial assistance with health insurance as of September 12, 2017, and to apply it effective October 1, 2017, as noted above.

At present, your child has CHP plan coverage with a $9.00 premium as of October 1, 2017, as aid to continue during the appeal process. Your child's enrollment will not be disturbed until your eligibility is redetermined by NYSOH. NYSOH will notify you of its redetermination and what further action may be required on your part, if applicable.

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 September 13, 2017 eligibility determination notice is RESCINDED.

NYSOH improperly determined that your child was eligible for CHP at full cost as of the September 12, 2017 redetermination.

Your case is sent back to NYSOH to redetermine your child's eligibility for financial assistance with health insurance as of September 12, 2017, and to apply it effective October 1, 2017, as noted above.

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At present, your child has CHP plan coverage with a $9.00 premium as of October 1, 2017, as aid to continue during the appeal process. Your child's enrollment will not be disturbed until your eligibility is redetermined by NYSOH. NYSOH will notify you of its redetermination and what further action may be required on your part, if applicable.

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:

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 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.

(Urdu)اردو

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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