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

Notice of Decision

Decision Date: March 7, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025636

[redacted]

Dear [redacted],

On March 2, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 6 and 7, 2017 eligibility determination notices.

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: March 7, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000025636

[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 as of January 1, 2018?

Procedural History

On December 6, 2017, you submitted an application for financial assistance through NYSOH.

On December 6 and 7, 2017, NYSOH issued eligibility determination notices stating that your child was eligible to enroll in a Child Health Plus at full cost, effective as of January 1, 2018.

Also on December 6 and 7, 2017, NYSOH issued plan enrollment notices confirming that as of December 5 and 6, 2017, your child was enrolled in a Child Health Plus plan with an enrollment start date of December 1, 2017.

On December 11, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as your child was not eligible to receive financial assistance.

On March 2, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was fully developed. The record was closed at the end of the hearing.

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Findings of Fact

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

1) According to your NYSOH account, you are only applying for health insurance for your child.

2) According to your NYSOH account and testimony, your child was born on [redacted]

3) According to your NYSOH account and testimony, you expect to file your 2017 and 2018 federal income tax returns with the tax status of Head of Household (with qualifying individual), and expect to claim your child as your only tax dependent on that return.

4) According to your December 6, 2017 application, you expected your yearly income to be $67,000.00.

5) According to your December 6, 2017 application, you did not expect to claim any deductions on your 2018 federal income tax return.

6) You testified that you expected your yearly income to be $72,000.00.

7) On December 6, 2017, you submitted an itemized list of your monthly living expenses. The list included, in part: rent; child care; car payments and insurance; groceries, and utilities (*see* Document [redacted]).

8) You testified that you want your monthly living expenses to be considered when your child's financial assistance is determined.

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)). 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)).

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“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 (26 USC § 262(a)).

Household Composition

Generally, a tax dependent’s household is the same as the household of the taxpayer who is claiming them as a tax dependent (42 CFR § 435.603(f)(2)).

Child Health Plus

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)).

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)).

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 2017 FPL, which was $16,240.00 for a two-person household (82 Federal Register 8831).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child was eligible to enroll in a Child Health Plus plan at full cost as of December 6, 2017.

The record reflects that you expect to file your 2017 and 2018 federal income tax returns, with the tax status of Head of Household (with qualifying individual), and expect to claim your child as your only dependent on that return. Generally, a tax dependent’s household is the same as the household of the taxpayer who is claiming them as a tax dependent. Therefore, your child is in a two-person household for purposes of this analysis.

In your December 6, 2017 application, you attested to an expected household income of $67,000.00. Further, on December 6, 2017, you submitted an itemized list of your monthly living expenses. The list included, in part: rent; child care; car payments and insurance; groceries, and utilities (Document [redacted]. You testified that you want your monthly living expenses to be considered when your child's financial assistance is determined.

Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income. Therefore, these expenses cannot be considered when computing your child's eligibility for financial assistance.

A child is eligible to enroll in a Child Health Plus with financial assistance, if they meet the non-financial requirements and have a household income below 400% FPL. On the date of your application, the relevant FPL was $16,240.00 for a two-person household.

A household income of $67,000.00 is 412.56% of the 2017 FPL for a two-person household. Therefore, NYSOH properly determined your child eligible to enroll in a Child Health Plus at full cost and the December 6 and 7, 2017 eligibility determination notices to this effect are AFFIRMED.

During the hearing, you testified that your expected 2018 yearly income would be approximately $72,000.00. Since your expected household income has only increased, your case will not be returned to NYSOH to recalculate your child's eligibility for financial assistance.

Decision

The December 6 and 7, 2017 eligibility determination notices are AFFIRMED.

Effective Date of this Decision: March 7, 2018

How this Decision Affects Your Eligibility

Your child remains eligible for Child Health Plus at full cost.

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):

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- 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 December 6 and 7, 2017 eligibility determination notices are AFFIRMED.

Your child remains eligible for Child Health Plus at full cost.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 CFR § 155.545.

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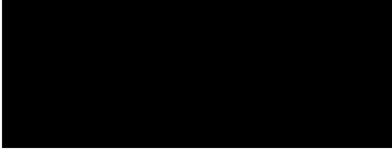
A Copy of this Decision Has Been Provided To:



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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.

(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۔

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.

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.

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