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

Notice of Decision

Decision Date: March 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026134

[redacted]

Dear [redacted],

On February 27, 2018, your spouse appeared by telephone at a hearing on your appeal of NY State of Health's December 21, 2017 eligibility determination.

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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: March 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026134

[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 with a $60.00 per month premium, effective February 1, 2018?

Procedural History

On December 20, 2017, NYSOH received your application for health insurance. That day, a preliminary eligibility determination was prepared stating that your child was eligible to enroll in Child Health Plus with a $60.00 monthly premium.

Also on December 20, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary determination insofar as your child was eligible for coverage through Child Health Plus with a $60.00 monthly premium, and not eligible for lesser monthly premium.

On December 21, 2017, NYSOH issued an eligibility determination notice, based on the December 20, 2017 application, stating that your child was eligible to enroll in Child Health Plus with a $60.00 monthly premium, effective February 1, 2018. The notice further stated that she was not eligible for Medicaid because your income of $73,512.00 was over the allowable limit for that program.

On February 27, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, your spouse and joint account holder, [redacted], appeared and gave testimony on your behalf. During the hearing, he waived your right to the 15-day formal notice of hearing. The record was developed during the hearing and held open up to March 14, 2018, to allow you time to submit supporting documents.

On February 27, 2018, NYSOH received your supporting documents by upload. 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) Your spouse testified that you expect to file your 2018 tax return with a tax filing status of married filing jointly. You will claim your child as a dependent on that tax return.

2) The application that was submitted on December 20, 2017 listed an annual household income of $73,512.00, consisting of $872.00 per month your spouse receives in pensions and annuities, $2,860.00 per month your spouse receives in Social Security benefits, $1,400.00 per month your spouse receives in IRA distributions, $994.00 you receive in Social Security benefits, and $994.00 your child receives in Social Security benefits. Your spouse testified that this amount was incorrect.

3) Your spouse testified that he mistakenly added your child's Social Security benefits with his Social Security benefits. He submitted documentation to show that he receives $2,000.00 per month in Social Security benefits.

4) Your spouse testified that he did not believe that his IRA distributions in the amount of $1,400.00 per month should be included in your annual household income for eligibility purposes.

5) At the time of your December 20, 2017 application, your child was [redacted]

6) Your application states that you will not be taking any deductions on your 2018 tax return.

7) On February 27, 2018, your spouse uploaded his Social Security benefit statement showing that he receives $2,000.00 per month, your child's Social Security benefit statement in the amount of $994.00 per month, your Social Security benefit statement in the amount of $994.00 per

month, and his pension and annuities statement in the amount of $872.76 per month.

8) Your application states that you live in Wayne County.

9) Your spouse testified that you would like your child to be eligible for Child Health Plus with a premium of less than $60.00 per month.

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)).

The CHP premium is $15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than $54.00 per month per family (NY PHL § 2510(9)(d)(iii)).

The CHP premium is $30.00 per month for a child whose family household income is between 251% and 300% of the FPL, but no more than $90.00 per month per family (NY PHL § 2510(9)(d)(iv)).

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)).

The CHP premium is $60.00 per month for a child whose family household income is between 351% and 400% of the FPL, but no more than $180.00 per child (NY PHL § 2510(9)(d)(vi)).

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 $20,420.00 for a three-person household (80 Federal Register 3236, 3237).

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” (MAGI) 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)).

The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

Unearned income is generally all income other than salaries, wages and other amounts received as pay for work actually performed, including taxable interest, dividends, capital gains (including capital gain distributions), the taxable part of social security and pension payments, certain distributions from trusts, and unemployment compensation. (IRS Publication 929, pg. 15).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child was eligible to enroll in Child Health Plus with a $60.00 per month premium.

According to the record, you expect to file a joint federal income tax return for the 2018 tax year and claim your one child as a dependent. Therefore, your child is in a three-person household.

In your December 20, 2017 application, you attested to an expected household income of $73,512.00. The application also stated that your child is [redacted]. NYSOH relied upon this information.

During the hearing, you asked that your spouse's IRA distribution income of $1,400.00 per month not be considered when calculating your annual household income however, NYSOH bases its eligibility determinations on modified adjusted gross income which includes unearned income from IRA distributions. Therefore, NYSOH correctly determined your household income to be $73,512.00 based on the information you provided on your December 20, 2017 application.

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 351% and 400% of the FPL are responsible for a $60.00 per month Child Health Plus premium payment. On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Since $73,512.00 is 360% of the 2017 FPL, NYSOH properly found your child to be eligible for Child Health Plus with a $60.00 per month premium payment.

Since the December 20, 2017 eligibility determination properly stated that, based on the information you provided, your child was eligible for Child Health Plus with a $60.00 per month premium, it is correct and is AFFIRMED.

However, you testified that you mistakenly reported your spouse's Social Security benefit amount as $2,860.00 per month because you included your child's Social Security benefits. You also submitted your spouse's Social Security benefits statement which shows that your spouse only receives $2,000.00 per month in Social Security benefits not $2,860.00 per month as reported on your December 20, 2017 application.

The Social Security benefits income of a child who is not required to file a tax return is not included in household income.

Therefore, your case is RETURNED to NYSOH to redetermine your child's eligibility for financial assistance for insurance based on your updated information. NYSOH is directed to determine your child's eligibility based on a three-person household, residing in Wayne County, with an annual household income of $63,192.00, which is your annual household income less your child's Social Security benefits which you incorrectly listed in your income section of your application.

Decision

The December 21, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your child's eligibility for financial assistance for insurance based on a three-person household, residing in Wayne County, with an annual household income of $63,192.00, which is your annual household income less your child's monthly $994.00 Social Security benefit which you incorrectly included in your Social Security benefit information in your application.

Effective Date of this Decision: March 26, 2018

How this Decision Affects Your Eligibility

NYSOH properly found your child eligible for Child Health Plus with a $60.00 per month premium based on the information you had entered in your application.

Your case is being sent back to NYSOH to redetermine your child's eligibility based on the income documentation you submitted following your hearing.

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 December 21, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly found your child eligible for Child Health Plus with a $60.00 per month premium based on the information you had entered in your application.

Your case is RETURNED to NYSOH to redetermine your child's eligibility for financial assistance for insurance based on a three-person household, residing in Wayne County, with an annual household income of $63,192.00, which is your annual household income less your child's monthly $994.00 Social Security benefit which you incorrectly included in your Social Security benefit information in your application.

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।

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).

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.

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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