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

Notice of Decision

Decision Date: April 21,2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013906

[redacted]

Dear [redacted],

On March 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 4, 2016 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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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: April 21,2017

NY State of Health Account ID:
Appeal Identification Number: AP000000013906

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 each of your children were eligible to enroll in Child Health Plus with a $15.00 per month premium each, effective January 1, 2017?

Procedural History

On September 29, 2016, you completed an application for financial assistance with NYSOH.

On September 30, 2016, NYSOH issued an enrollment confirmation notice stating that your three children were enrolled in a Child Health Plus plan, with a $9 monthly premium each, effective November 1, 2016. The notice directed you to provide income information for your three children by November 27, 2016. The notice stated that if you miss the due date, you may lose insurance or receive less help paying for your coverage.

On October 7, 2016, NYSOH issued an eligibility determination stating that your children were eligible for Child Health Plus for a limited time, with a $9.00 monthly premium each, effective November 1, 2016. The notice stated directed you to provide income information for your three children by November 27, 2016. The notice stated that if you miss the due date, you may lose insurance or receive less help paying for your coverage.

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On October 8, 2016, NYSOH issued an eligibility determination stating that your children were eligible for Child Health Plus for a limited time, with a $9.00 monthly premium each, effective November 1, 2016. The notice directed you to provide income information for your three children by November 27, 2016. The notice stated that if you miss the due date, you may lose insurance or receive less help paying for your coverage.

On October 14, 2016, NYSOH issued an enrollment confirmation notice stating that your three children were enrolled in a Child Health Plus plan, with a $9.00 monthly premium each, with a plan start date of November 1, 2016. The notice directed you to provide income information for your three children by November 27, 2016. The notice stated that if you miss the due date, you may lose insurance or receive less help paying for your coverage.

No income documentation was received by November 27, 2016.

On December 3, 2016, NYSOH redetermined your eligibility.

On December 4, 2016, NYSOH issued an eligibility determination stating that your three children were eligible for Child Health Plus, with a $15.00 monthly premium per child, effective January 1, 2017. The notice stated that your children's eligibility was redetermined based on information from federal and state data because you did not send in documentation to confirm the income listed in your application.

Also on December 4, 2016, NYSOH issued an enrollment confirmation notice stating that your children were enrolled in a Child Health Plus plan, with a $15.00 monthly premium each, effective November 1, 2016.

On December 8, 2016, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your children were found to be eligible for Child Health Plus at a cost of $15.00 per month each, effective January 1, 2016.

On March 24, 2017, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and left open for 15 days to allow you to submit income documentation. On March 24, 2017, the Appeals unit received via fax, a letter to NYSOH stating that you were the sole income in your household and a letter from your employer stating your annual income. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

Findings of Fact

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

1) You testified that you received the September 30, 2016 eligibility determination from NYSOH directing you to provide income information for your three children by November 27, 2016.

2) You testified that you faxed income documentation to NYSOH on October 6, 2016 consisting of a letter indicating that you that your income supports your family and a letter dated October 6, 2016 from the [redacted] stating that you are employed as a [redacted] and that your annual income is $52,217.00.

3) You testified that you received a letter from NYSOH dated October 14, 2016 requesting that you provide income information for your three children by November 27, 2016.

4) You testified that you called NYSOH and asked whether they had received the documentation that you had faxed to them on October 6, 2016. You testified that a NYSOH representative advised you that there was no record that they received income documentation from you.

5) NYSOH records do not reflect receipt of income documentation from you.

6) On December 4, 2016, your children were redetermined eligible for Child Health Plus with a monthly premium of $15.00 each, effective January 1, 2017.

7) You testified that you expected to file your 2016 taxes with a tax filing status of married filing jointly. You will claim your three children as dependents on that tax return.

8) You testified that you have an annual household income of $52,217.00, consisting of $52,217.00 you expected to earn from your employment with [redacted]. You testified that this amount was correct.

9) According to your September 29, 2016 application your children were [redacted] [redacted] years old, respectively.

10) You testified that you did not anticipate taking any deductions on your 2016 tax return.

11) You testified that you live in [redacted], New York.

12) You testified that you are seeking for your children's Child Health Plus plan coverage during 2017 to continue at $9.00 per month, rather than the

$15.00 per month premium your children were found eligible for after NYSOH redetermined their eligibility in December 2016.

13) On March 24, 2017, NYSOH Appeals Unit received income information from you consisting of a letter to NYSOH stating that you were the sole income in your household and a letter from your employer stating your annual income.

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

Applicable Law and Regulations

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)).

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 NY Public Health Law § 2510 et seq. and 42 USC § 1397(a)). Eligibility rules are set out in NY Public Health Law § 2511(2), as well as in the NYSDOH 2008-2012 Contract and Plan Manual.

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in CHP depends upon the child's family household income (PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL. If the family household income is 160% or higher, premiums range from $9.00 per month to $60.00 per month (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 (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 (PHL § 2510(9)(d)(iii)).

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 2016 FPL, which was $28,440.00 for a five-person household (80 Federal Register 3236, 3237).

Legal Analysis

The only issue under review is whether NYSOH properly determined that each of your children were eligible to enroll in Child Health Plus (CHP) with a $15.00 per month premium, effective January 1, 2017.

According to your testimony, you expect to file a joint federal income tax return for the 2016 tax year and claim your three children as dependents. Therefore, each of your children is in a five-person household.

Based on the documentation you provided on March 24, 2017, your expected household income is $52,217.00. 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 federal poverty level (FPL). Household income between 160% and 222% of that FPL are responsible for a $9.00 per month Child Health Plus premium payment.

Since $52,217.00 is 183.60% of the 2016 FPL, your children should have been found eligible for Child Health Plus with a $9.00 per month premium payment each. NYSOH's December 4, 2016 eligibility determination found that your three children were eligible for Child Health Plus, with a $15.00 monthly premium per child each, effective January 1, 2017.

Since the income documentation you provided on March 24, 2017 contradicts the findings made by NYSOH, the December 14, 2016 eligibility determination is RESCINDED and your case is RETURNED to NYSOH to redetermine your children's eligibility for the Child Health Plus program, with a $15.00 monthly premium per child each, effective January 1, 2017 based on a five-person household with an annual income of $52,217.00 living in [redacted].

Decision

The December 4, 2016 eligibility determination is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your children's eligibility for the Child Health Plus program with a $15.00 per month premium each, effective January 1, 2017 based on a five-person household with an annual income of $52,217.00 living in [redacted].

Effective Date of this Decision: April 21, 2017

How this Decision Affects Your Eligibility

Your case is being RETURNED to NYSOH to redetermine your children's eligibility for the Child Health Plus program with a $15.00 per month premium each, effective January 1, 2017 based on a five-person household with an annual income of $52,217.00 living in [redacted].

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 4, 2016 eligibility determination is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your children's eligibility for the Child Health Plus program with a $15.00 per month premium each, effective January 1, 2017 based on a five-person household with an annual income of $52,217.00 living in [redacted].

Legal Authority

We are issuing this determination in accordance with 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.

(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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