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

Notice of Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015740

[redacted]

Dear [redacted],

On May 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 22, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015740

[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 three children were eligible to enroll in a full cost Child Health Plus plan with a $213.87.00 per month premium each, effective March 1, 2017?

Procedural History

On November 16, 2016, you updated your application for financial assistance with NYSOH.

On November 17, 2016, NYSOH issued a notice of eligibility redetermination stating that your children were eligible for a Child Health Plus plan, with a monthly premium of $45.00 each, for a limited time, effective January 1, 2017. The notice directed you to provide income documentation by January 15, 2017. The notice stated that if you missed the due date, that you might lose your insurance or receive less help paying for your coverage.

Also, on November 17, 2016, NYSOH issued an enrollment confirmation notice stating that your three children were enrolled in a Child Health Plus plan, with a $45.00 monthly premium each, effective January 1, 2017.

No income documentation was provided by January 15, 2017.

On January 21, 2017, NYSOH redetermined your eligibility.

On January 22, 2017, NYSOH issued an eligibility determination stating that your three children were eligible for a full price Child Health Plus plan, effective March 1, 2017.

Also on January 22, 2017, NYSOH issued an enrollment confirmation notice stating that your children were enrolled in a Child Health Plus plan, with a $641.61 combined monthly premium, effective March 1, 2017.

On February 10, 2017, you spoke to NYSOH's Account Review Unit and appealed your children's eligibility insofar as they were found to be eligible for Child Health Plus at a cost of $213.87.00 per month each, that is, full cost, effective March 1, 2017.

On February 17, 2017, NYSOH issued an eligibility redetermination notice stating that your children were eligible for Child Health Plus, each with a $45.00 monthly premium, in the form of "Aid to Continue," effective March 1, 2017.

On May 17, 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 May 18, 2017, the Appeals unit received via fax, a letter from your employer indicating your gross annual income and pay stubs with pay dates in January 2017. 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 November 17, 2016 notice from NYSOH directing you to provide income documentation by January 15, 2017.

2) You testified that you did not provide the documentation requested.

3) On January 22, 2017, your children were redetermined eligible for a full price Child Health Plus plan, effective March 1, 2017.

4) After the hearing, on May 18, 2017, you faxed a letter from your employer, [redacted], dated May 18, 2017 which indicated that your gross annual salary in 2016 was $80,953.88 and that your projected salary for 2017 was between $80,000.00 and $90,000.00.
5) Also on May 18, 2017, you faxed documentation to NYSOH consisting of four weeks' worth of paystubs for you, representing the income you received in the month of January 2017. The fax consisted of the following:

a. Two biweekly paystubs for you, for the following dates and gross taxable amounts:
    i. January 8, 2017: $1,849.33;
    ii. January 20, 2017: $2,637.16.

6) You testified that you expected to file your 2017 taxes with a tax filing status of single. You will claim your three children as dependents on that tax return.

7) You testified that you have an annual household income of approximately $80,900.00, consisting of $80,900.00 you expected to earn from your employment with [redacted]. You testified that this amount was correct.

8) You testified that you expected your income to stay the same in 2017.

9) According to your November 16, 2016 application, your children were [redacted], [redacted], and [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 Monroe County, New York.

12) NYSOH issued an eligibility redetermination notice stating that your children were eligible for Child Health Plus, in the form of Aid to Continue, effective March 1, 2017.

13) You testified that you are seeking that your children be determined eligible for a Child Health Plus plan with a monthly premium of $45.00 each.

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. Premiums will not be subsidized if income is over 400% of the FPL (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, January 21, 2017 application, that was the 2016 FPL, which was $24,300.00 for a four-person household (81 Federal Register 4036).

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 with a $213.87.00 per month premium each, that is, a full cost plan, effective March 1, 2017.

According to your testimony, you expect to file a single federal income tax return for the 2017 tax year and claim your three children as dependents. Therefore, each of your children is in a four-person household.

Based on the letter from your employer you provided on May 18, 2017, your expected household income will be between $80,000.00 and $90,000.00. Although you testified that you expected to earn about the same as you did last year, this is not fully supported by the May 17, 2017 letter from your employer, and no current pay stubs have been submitted. Therefore, we will use the higher income documented by your employer.

A child is eligible to enroll in Child Health Plus, and to receive premium subsidies, 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).

Since $90,000.00 is 370.37% of the 2016 FPL, your children should have been found eligible for a subsidized premium payment. NYSOH's January 22, 2017 eligibility determination found that your three children were eligible for Child Health Plus, with a $213.87.00 monthly premium per child each, effective March 1, 2017, which reflects the unsubsidized premium.

Since the income documentation you provided on May 18, 2017 contradicts the findings made by NYSOH, the January 22, 2017 eligibility determination is RESCINDED and your case is RETURNED to NYSOH to redetermine your children's eligibility for the Child Health Plus program, based on a four-person household with an annual income of $90,000.00 living in Monroe County.

Decision

The January 22, 2017 eligibility determination is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your children's eligibility for the Child Health Plus program, based on a four-person household with an annual income of $90,000.00 living in Monroe County.

Effective Date of this Decision: June 28, 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, based on a four-person household with an annual income of $90,000.00 living in Monroe County.

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 January 22, 2017 eligibility determination is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your children's eligibility for the Child Health Plus program, based on a four-person household with an annual income of $90,000.00 living in Monroe County.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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.

□□□□□ (Bengali)

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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.

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)

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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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