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

Notice of Decision

Decision Date: July 27, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000017608

[redacted]

Dear [redacted],

On July 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 4, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: July 27, 2017

NY State of Health Number: [redacted]
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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 (CHP) at full cost, effective May 1, 2017?

Procedural History

On January 3, 2017, NYSOH received your updated application for health insurance, which listed an expected annual income of $46,800.01.

On January 4, 2017, NYSOH issued a notice of eligibility determination, based on your January 3, 2017 application, stating that your child was eligible to enroll in CHP with a $30.00 monthly premium for a limited time, effective February 1, 2017. The notice also directed you to submit documentation of your income by March 4, 2017.

Also on January 4, 2017, NYSOH issued a notice of enrollment confirmation, confirming your child's enrollment in a CHP plan with a $30.00 monthly premium, beginning February 1, 2017.

On March 10, 2017, NYSOH's system redetermined your household's eligibility.

On March 11, 2017, NYSOH issued a notice of eligibility determination stating that your child was eligible to enroll in a CHP plan at full cost, effective April 1, 2017. The notice further stated that your child was eligible to enroll at full cost

because state and federal data sources showed that your household income was more than $64,960.00.

Also on March 11, 2017, NYSOH issued a notice stating that your child was enrolled in a CHP plan with a monthly premium of $192.26, beginning April 1, 2017.

On April 3, 2017, you updated your NYSOH account and changed your expected annual income to $69,000.00. That same day, NYSOH prepared a preliminary eligibility determination stating that your child was eligible to enroll in a CHP plan at full cost, effective May 1, 2017.

Also on April 3, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination, insofar as your child was not eligible for CHP premium assistance.

On April 4, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible to enroll in a CHP plan at full cost, effective May 1, 2017. The notice further stated that your child was eligible for a full cost plan because the income listed in your application was $69,000.00, which was over the allowable income limit of $64,960.00.

Also on April 4, 2017, NYSOH issued a notice of enrollment confirmation, confirming your child's enrollment in a CHP plan with a monthly premium of $232.21, beginning April 1, 2017.

On July 18, 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 head of household with qualifying individual. You will claim your child as a dependent on that tax return.

2) The application that was submitted on April 3, 2017 listed annual household income of $69,000.00, consisting of income you earn from employment. You testified that you believe this amount was correct.

3) You testified that you work between 35 and 37.5 hours per week, and that you earn $39.00 an hour.

4) You testified that you do not plan to take any deductions on your 2017 tax return.

5) At the time of your April 3, 2017 application, your child was [redacted] years old.

6) Your application states that you live in [redacted].

7) You testified that you would like to be eligible for financial assistance with the cost of your child's CHP coverage, as you are a single mother and cannot afford the monthly premium for her coverage. You testified that you do not understand why your premium amount "jumped up" to hundreds of dollars.

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

Applicable Law and Regulations

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 family (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 is $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 CHP at full cost, effective May 1, 2017.

According to the record, you expect to file your 2017 federal income tax return as head of household with qualifying individual, and to claim your one child as a dependent. Therefore, your child is in a two-person household.

In your April 3, 2017 application, you attested to an expected household income of $69,000.00. The application also stated that your child is [redacted] years old. NYSOH relied upon this information.

A child is eligible to enroll in CHP with premium assistance if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $69,000.00 is 424.88% of the 2017 FPL, NYSOH properly found your child to be eligible for CHP at full cost, and to be ineligible for any CHP premium assistance.

You testified that you do not understand why your child's CHP premium amount increased so much. The application that you filed in January 2017 listed an expected annual income of $46,800.01. At that income amount, your child was eligible for CHP with a $30.00 per month premium. However, that eligibility was

only for a limited time, as NYSOH asked you to provide income documentation. When income documentation was not provided, NYSOH reran your eligibility in March 2017, and your child was found eligible for CHP at full cost, based on income information from state and federal data sources. When you updated your application on April 3, 2017, you listed an expected gross annual income of $69,000.00. As this is a more than $22,000.00 increase from the amount listed in your January 2017 application, your child was no longer eligible for CHP premium assistance.

Therefore, the April 4, 2017 eligibility determination properly stated that, based on the information you provided, your child was eligible to enroll in a CHP plan at full cost, effective May 1, and is AFFIRMED.

Decision

The April 4, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: July 27, 2017

How this Decision Affects Your Eligibility

Your child remains eligible for CHP at full cost.

Your child is not eligible for CHP premium assistance.

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 April 4, 2017 eligibility determination notice is AFFIRMED.

Your child remains eligible for CHP at full cost and your child is not eligible for CHP premium assistance.

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).

A Copy of this Decision Has Been Provided To:

[redacted]

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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)

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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।

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)

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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