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

Notice of Decision

Decision Date: October 10, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000019580

[redacted]

Dear [redacted]

On September 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 7, 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 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: October 10, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000019580

[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 a full price Child Health Plus plan, effective July 1, 2017?

Procedural History

On May 13, 2016, NYSOH received your application for health insurance for your child.

On May 14, 2016, NYSOH issued a notice of eligibility determination stating that your child was eligible for Child health Plus with a $30.00 monthly premium, effective June 1, 2016.

Also on May 14, 2016, NYSOH issued a notice of enrollment confirmation, stating that your child was enrolled in a Child Health Plus plan with a $30.00 monthly premium.

On April 6, 2017, NYSOH issued a renewal notice stating that your child was eligible to enroll in a full price Child Health Plus plan, effective June 1, 2017. The notice further stated that she was not eligible for a Child Health Plus subsidy because federal and state data sources showed that your household income was over the allowable income limit for that program.

On April 17, 2017, NYSOH issued an enrollment confirmation notice stating that your child was enrolled in a Child Health Plus plan with a $218.53 monthly premium and a plan enrollment start date of June 1, 2017.

On April 27, 2017, you contacted NYSOH and updated your child's application for health insurance.

On April 28, 2017, NYSOH issued a notice of eligibility determination stating that your child was eligible to enroll in a full price Child Health Plus plan, effective June 1, 2017. The notice further stated that she was not eligible for a Child Health Plus subsidy because your household income was over the allowable income limit for that program.

On June 6, 2017, you updated your child's application for health insurance. That day, NYSOH prepared a preliminary eligibility determination stating that your child was eligible to enroll in a full price Child Health Plus plan.

Also on June 6, 2017, you spoke to NYSOH's Account Review unit and appealed that determination insofar as your child was ineligible for a Child Health Plus subsidy.

On June 7, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible to enroll in a full price Child Health Plus plan, effective July 1, 2017. The notice further stated that she was not eligible for a Child Health Plus subsidy because your household income was over the allowable income limit for that program.

On June 9, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for Child Health plus for a limited time, effective July 1, 2017. This was because your child had been granted Aid to Continue until a decision was made on your appeal.

On June 9, 2017, NYSOH issued a notice of enrollment confirmation stating that your child was enrolled in a Child Health Plus plan with a $30.00 monthly premium and a plan enrollment start date of June 1, 2017.

On September 7, 2017, you were scheduled for a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You requested that day that the hearing be adjourned to a later date.

On September 13, 2017, you had an adjourned telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Under oath, you waived your right to formal notice of the hearing. The record was developed during the hearing and left open for twenty-one days to allow you the opportunity to submit additional income documentation.

On October 3, 2017, you uploaded four of your spouse's paystubs to your NYSOH account. These documents are marked as [redacted] and are hereby 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 expect to file your 2017 tax return with a tax filing status of married filing jointly and you will claim your one child as a dependent on that tax return.

2) The application that was submitted on June 6, 2017 listed annual household income of $113,200.00, consisting of $115,000.00 your spouse earns from his employment less $1,800.00 your spouse deducts in student loan interest. You testified that you are not sure if this amount is correct.

3) You testified that your spouse's income is based solely on commission and therefore it is difficult to predict.

4) You testified that as of the time of the hearing, your spouse's year to date net income was $65,000.00.

5) You testified that your spouse receives a paycheck every two weeks.

6) You testified that you do not have any income, have not had any income in 2017, and do not anticipate having any income in 2017.

7) At the time of your June 6, 2017 application, your child was [redacted].

8) Your application states, and you confirmed that you live in Suffolk County.

9) On October 3, 2017, you uploaded two of your spouse's paystubs to your NYSOH account:

    a. The first paystub is for pay period May 22, 2017 to June 4, 2017 paid on check date June 9, 2017 for a gross pay amount of $8,156.65 and a gross year to date amount of $71,598.95
    b. The second is for pay period June 5, 2017 to June 18, 2017 paid on check date June 23, 2017 for a gross pay amount of $4,403.47 and a gross year to date amount of $76,002.42
    c. The third is for pay period June 19, 2017 to July 2, 2017 paid on check date July 7, 2017 for a gross pay amount of $7,067.55 and a gross year to date amount of $83,069.97

d. The fourth is for pay period July 3, 2017 to July 16, 2017 paid on check date July 21, 2017 for a gross pay amount of $1,214.34 and a gross year to date amount of $84,284.31

10) You testified that you are seeking for your child to be found eligible for a Child Health Plus subsidy.

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.

To be eligible for Child Health Plus, the child:

- Must be under 19 years of age;
- Must be a New York State Resident;
- Must not have other health insurance coverage; and
- Must not be eligible for, or enrolled in, Medicaid

(NY Public Health Law § 2511(2)(a)-(e)).

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 is $20,420.00 for a three-person household (82 Fed. Reg. 8831).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child was eligible to enroll in a full price Child Health Plus, effective July 1, 2017.

According to the record, you expect to file your 2017 tax return as married filing jointly and will claim your one child as a dependent on that return. Therefore, your child is in a three-person household.

In your June 6, 2017 application, you attested to an expected household income of $113,200.00. The application also stated that your child is [redacted]. NYSOH relied upon this information.

A child is eligible to enroll in Child Health Plus with a subsidy if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the relevant FPL. On the date of your application, the relevant FPL was $20,420.00 for a three-person household. Households with an income above 400% of the FPL are not eligible to receive a Child Health Plus subsidy payment. Since $113,200.00 is 554.36% of the 2017 FPL, NYSOH

properly found your child eligible to enroll in a full price Child Health Plus plan and ineligible for a Child Health Plus subsidy.

Since the June 6, 2017 eligibility determination notice properly stated that, based on the information you provided, your child was eligible to enroll in a full price Child Health Plus plan, it is correct and is AFFIRMED.

During the hearing, you testified that your spouse's income is based solely on commission, and therefore it is difficult to determine your annual expected income.

Following the hearing you submitted four biweekly paystubs that show that over the course of eight weeks your spouse earned gross income of $20,842.01, therefore the weekly average is $2,605.25 multiplied by 52 weeks yields $135,473.07, less deductions of $1,800.00 results in an annual expected income of $133,673.07. As $133.673.07 is 654.62% of the 2017 FPL, the evidence in the record does not support a finding that your child is eligible for a Child Health Plus subsidy.

The paystubs also indicate that as of July 16, 2017 your spouse's year to date gross income was $84,284.31. This represents 28 weeks of pay, therefore using this methodology, your spouse's average weekly income is $3,010.15. When multiplied by 52 weeks, this yields $156.528.00, less deductions of $1,800.00 results in an annual expected income of $154,728.00. As $154,728.00 is 757.73% of the 2017 FPL, the evidence in the record does not support a finding that your child is eligible for a Child Health Plus subsidy.

Decision

The June 7, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 10, 2017

How this Decision Affects Your Eligibility

Your child remains eligible to enroll in a full price Child Health Plus plan.

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.

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).

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

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Summary

The June 7, 2017 eligibility determination notice is AFFIRMED.

Your child remains eligible to enroll in a full price Child Health Plus plan.

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)

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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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