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

Notice of Decision

Decision Date: December 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022334

[redacted]

[redacted]

On November 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 29, 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
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Decision

Decision Date: December 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022334

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NYSOH properly determine that your son was eligible to enroll in Child Health Plus with a $9.00 per month premium effective October 1, 2017?

Procedural History

On June 10, 2017, NYSOH received your son's application for health insurance.

On June 11, 2017, NYSOH issued an eligibility determination notice stating your son was eligible for Child Health Plus at a cost of $9.00 per month for a limited time, effective October 1, 2017. The notice requested you provide proof of your income by August 9, 2017.

On June 11, 2017, NYSOH issued an enrollment notice confirming your son's enrollment in a Child Health Plus plan for a cost of $9.00 per month, starting July 1, 2017.

On July 24, 2017, NYSOH received your son's updated application and you added your daughter to your application.

On July 25, 2017, NYSOH issued an eligibility determination notice stating your son was eligible for Child Health Plus for a cost of $0.00 for a limited time, effective September 1, 2017. Your daughter was determined eligible for Child Health Plus for a cost of $0.00, effective September 1, 2017. The notice requested proof of your household income by August 9, 2017.

On July 25, 2017, NYSOH issued an enrollment notice confirming your son and daughter's enrollment in a Child Health Plus plan for a cost of $0.00 per month for your son starting July 1, 2017 and September 1, 2017 for your daughter.

On August 28, 2017, NYSOH verified income documentation you provided and an application was submitted on your children's behalf based on that documentation.

On August 29, 2017, NYSOH issued an eligibility determination notice stating your son was eligible for Child Health Plus for a cost of $9.00 per month and your daughter was eligible for a premium of $0.00 per month, effective October 1, 2017.

On August 29, 2017, NYSOH issued an enrollment notice confirming your children's enrollment in a Child Health Plus plan, your son at $9.00 per month and your daughter at $0.00 per month, effective October 1, 2017.

On September 12, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your son was eligible for coverage through Child Health Plus for $9.00 per month.

On November 30, 2017, you had a telephone hearing with the aid of Spanish Interpreter [redacted] 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 your husband expects to file his 2017 tax return with a tax filing status of head of household. He will claim your two children as dependents on that tax return. You will not be filing taxes for 2017.

2) The application that was submitted on August 28, 2017 listed annual household income of $46,800.00, consisting of income your husband earns from his employment. You testified that you were not sure if this amount was correct. You testified only your husband earns income.

3) NYSOH reviewed income documentation provided on August 24, 2017 showing a gross income of $900.00 received on August 4, 2017, $900.00 received on August 16, 2017, $900.00 received on August 22, 2017, $900.00 received on August 26, 2017.

4) Your July 24, 2017 application states your annual household income would is $38,000.00.

5) At the time of your August 28, [redacted]

6) Your application states that you will not be taking any deductions on your 2017 tax return.

7) Your application states that you live in [redacted]

8) You testified that you would like both children to be determined eligible for $0.00 premium effective October 1, 2017.

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)).

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 $24,600.00 for a four-person household (82 Fed. Reg. 8831).

In the case where a child is claimed by one parent as a dependent and who is living with both parents who are not filing a joint tax return (42 CFR § 435.603(f)(2)(ii)), the child's family includes the following persons, if living with the child: (1) the child's parents, (2) the child's spouse, (3) the child's children and siblings under the age of 19, or 21 if a full-time student (42 CFR § 435.603(f)(3)).

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

Legal Analysis

The issue under review is whether NYSOH properly determined that your son with a $9.00 per month premium effective October 1, 2017.

According to the record, your husband will file his 2017 tax return with a filing status of head of household and will claim your two children as dependents. You will not be filing taxes. In the case where a child is claimed by one parent as a dependent and who is living with both parents who are not filing a joint tax return the child's household includes the child's parents and any sibling under age 19. Therefore, for purposes of this analysis your children reside in a four-person household.

On June 10, 2017, you applied for health insurance for only your [redacted] son. The result of that application was that he was determined conditionally eligible for Child Health Plus for a cost of $9.00 per month with proof of your income due by August 9, 2017.

On July 24, 2017, you first added your [redacted] daughter to your application.

In your July 24, 2017, application, you attested to an expected household income of $38,000.00. NYSOH relied upon this information. NYSOH determined that

both of your children were eligible for Child Health Plus for a cost of $0.00 per month. However, the determination still required income documentation for your son's eligibility to be complete but not for your daughter.

NYSOH reviewed income documentation you provided on August 24, 2017 showing an average annual household income of $900.00 per week, and an application was submitted with an annual household income of $46,800.00.

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 FPL. Households with an income between 160% and 222% of the FPL are responsible for a $9.00 per month Child Health Plus premium payment. On the date of your application, the relevant FPL was $24,600.00 for a four-person household. Since $46,800.00 is 190.24% of the 2017 FPL, NYSOH properly found your son to be eligible for Child Health Plus with a $9.00 per month premium payment.

However, your daughter remained eligible for the previous premium responsibility of $0.00 which she had been determined eligible for based on her July 24, 2017 application. NYSOH instituted a Child Health Plus "lock-in" period where a child who is newly eligible for that program will be locked into their initial premium payment for 12 months from the date of eligibility. Since your daughter's eligibility was redetermined with a higher annual income on August 24, 2017, she still remained eligible for the original premium amount until the end of her lock in period.

Since the August 29, 2017 eligibility determination notice properly stated that, based on the information you provided, your child was eligible for Child Health Plus with a $9.00 per month premium, it is correct and is AFFIRMED.

Decision

The August 29, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: December 15, 2017

How this Decision Affects Your Eligibility

Your son remains eligible for Child Health Plus with a $9.00 per month premium.

Your daughter remains eligible for Child Health Plus with a $0.00 per month premium.

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 August 29, 2017 eligibility determination notice is AFFIRMED.

Your son remains eligible for Child Health Plus with a $9.00 per month premium.

Your daughter remains eligible for Child Health Plus with a $0.00 per month premium.

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)

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).

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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