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

# Notice of Decision

Decision Date: December 7, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000022514

[redacted]

[redacted]

On November 13, 2017, you both appeared by telephone at a hearing on your appeal of NY State of Health's September 19, 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.

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DEPARTMENT OF HEALTH
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# Decision

Decision Date: December 7, 2017

NY State of Health Number: [redacted]
Appeal Identification Number: AP000000022514

[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 children were eligible to enroll in a full cost Child Health Plus plan, effective October 1, 2017 and November 1, 2017 respectively?

## Procedural History

On September 12, 2017, you updated your NYSOH application for health insurance for your two children.

On September 13, 2017, NYSOH issued an eligibility determination notice stating that your two children were eligible for a Child Health Plus (CHP) plan or a child-only qualified health plan at full cost, effective October 1, 2017.

Also on September 13, 2017, NYSOH issued a plan enrollment notice confirming your children's enrollment in a CHP plan with a $202.26 monthly premium each and a plan enrollment start date of October 1, 2017.

On September 18, 2017, you updated your NYSOH application for health insurance for your two children. That day, a preliminary eligibility determination was prepared finding your children eligible for a CHP plan or a child-only qualified health plan at full cost, effective November 1, 2017.

Also on September 18, 2017, you spoke to NYSOH's Account Review unit and appealed that determination insofar as your children were not eligible for a CHP subsidy.

On September 19, 2017, NYSOH issued an eligibility determination notice stating that your children were eligible to enroll in a full price CHP plan, effective November 1, 2017. The notice further stated that they were not eligible for a CHP subsidy because your household income was over the allowable income limit for that program.

Also on September 19, 2017, NYSOH issued a plan enrollment notice confirming your children's enrollment in a CHP plan with a $202.26 monthly premium each and a plan enrollment start date of October 1, 2017.

On November 13, 2017, you and your spouse had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until November 28, 2017 to allow you an opportunity to submit supporting documentation regarding your income.

On November 22, 2017, NYSOH Appeals Unit received via secure facsimile your 3-page submission consisting of two handwritten notes and your November 11, 2017 earnings statement. Those documents were made part of the record collectively as Appellant's Exhibit # 1. The record was closed at that time.

## Findings of Fact

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

1) You and your spouse testified that you expect to file your 2017 tax return with a tax filing status of married filing jointly. You will claim your two children as dependents on that tax return.

2) The application that was submitted on September 18, 2017 listed annual household income of $ 98,402.48, consisting of salary your spouse earns from his employment. Your spouse testified that this amount was correct.

3) According to your NYSOH account and your spouse's testimony, he is paid 26 times a year and he receives $3,784.71 in gross wages each paycheck.

4) At the time of your September 18, 2017 application, your oldest child was [redacted]

5) According to your NYSOH account, your September 18, 2017 application states that you will not be taking any deductions on your 2017 tax return.

6) According to your NYSOH account and your testimony, your family lives in Orange County, New York.

7) You testified that you would like your children to be eligible for CHP subsidy to lower their monthly premium.

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 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 child (NY PHL § 2510(9)(d)(vi)).

In an analysis of CHP 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 was $24,600.00 for a four-person household (82 Federal Register 8831).

## Legal Analysis

The issue under review is whether NYSOH properly determined that your children were eligible to enroll in a CHP plan at full cost, effective October 1, 2017.

According to the record, you expect to file a joint federal income tax return for the 2017 tax year and claim your two children as dependents. Therefore, your children are in a four-person household. The application also stated that your oldest child is [redacted] NYSOH relied upon this information.

In your September 18, 2017 application, you attested to an expected household income of $98,402.48. According to your NYSOH account and your spouse's testimony, he is paid 26 times a year and receives $3,784.71 in gross wages each paycheck. Therefore, according to the information you supplied, your annual household income is $98,402.46 (26 x $3784.71). This amount is only 2 cents less than the household income attested to in the September 18, 2017 application. NYSOH relied on the $98,402.48 amount of household income as attested in the September 18, 2017 application in determining your children's eligibility for financial assistance and this analysis will be based on that amount.

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. On the date of your application, the relevant 2017 FPL was $24,600.00 for a four-person household. Households with an income above 400% of the FPL are not eligible to receive a CHP subsidy payment. Since $98,402.48 is 400.01% of the 2017 FPL, NYSOH properly found your children eligible to enroll in a full price CHP plan and ineligible for a CHP subsidy.

Since the September 13 and 19, 2017 eligibility determination notices properly stated that, based on the information you provided, your children were eligible to enroll in a full price CHP plan, those notices are correct and are AFFIRMED.

## Decision

The September 13 and 19, 2017 eligibility determination notices are AFFIRMED.

## **Effective Date of this Decision:** December 7, 2017

## How this Decision Affects Your Eligibility

This decision does not change your children's eligibility for CHP or enrollment in a CHP plan

Your children were properly determined eligible to enroll in a full price CHP plan as of October 1, 2017 and November 1, 2017 respectively.

## 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 September 13 and 19, 2017 eligibility determination notices are AFFIRMED.

This decision does not change your children's eligibility for CHP or enrollment in a CHP plan

Your children were properly determined eligible to enroll in a full price CHP plan as of October 1, 2017 and November 1, 2017 respectively.

## 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)**

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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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