STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: December 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022545

[redacted]

On November 29, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 13, 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
  PO 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(b).

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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Decision

Decision Date: December 7, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022545

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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 two children were eligible to enroll in a full price Child Health Plus plan, effective October 1, 2017?

Procedural History

On July 7, 2017, you updated your NYSOH account and uploaded proof of income.

On July 8, 2017, NYSOH issued an eligibility determination stating that your two children were conditionally eligible for Child Health Plus with a monthly premium of $45.00 each, effective August 1, 2017. The notice directed you to provide proof of income by September 5, 2017.

Also, on July 8, 2017, NYSOH issued an enrollment confirmation notice stating that your two children were enrolled in Child Health Plus, effective August 1, 2017.

On July 11, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the income listed in your application. The notice directed you to provide proof of income by September 5, 2017.

No additional documentation was submitted.

On September 12, 2017, NYSOH redetermined your eligibility.

On September 13, 2017, NYSOH issued an eligibility determination stating that your two children were eligible to enroll in a full price Child Health Plus plan, effective October 1, 2017. The notice also stated that your children were not eligible for financial assistance with the cost of their Child Health Plus plan premiums because information from state and federal data sources showed that your household income was more than $98,400.00.

Also on September 13, 2017, NYSOH issued a notice of enrollment confirmation, confirming that your children were enrolled in a Child Health Plus plan with a monthly premium of $192.39 each, effective October 1, 2017.

On September 19, 2017, you updated your NYSOH application. That day, NYSOH prepared a preliminary eligibility determination stating that your children were eligible to enroll in Child Health Plus with a $60.00 monthly premium, each, effective November 1, 2017.

Also on September 19, 2017, you spoke to NYSOH's Account Review Unit and appealed, insofar as your children were not eligible for Child Health Plus premium assistance in the month of October 2017.

On September 22, 2017, NYSOH issued a notice of enrollment confirmation, confirming that your children were enrolled in a Child Health Plus plan with a $60.00 monthly premium each, beginning November 1, 2017.

On November 29, 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) Your NYSOH account reflects that you updated your application on July 7, 2017. You attested to a 2017 household income of $84,177.00.

2) You testified, and your NYSOH account reflects, that you also uploaded income documentation on July 7, 2017 consisting of your 2016 federal tax return.

3) In the "Notes" tab of your NYSOH account, there is a note entered on July 10, 2017 stating "Invalid proof of income. [redacted]ubmitted an undated and unsigned 2016 – 1040. [redacted]

Documents Fact Sheet for additional documents. The clock open date is 7/7/2017. No Due date extension necessary."

4) On July 11, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the income listed in your application. The notice directed you to provide proof of income by September 5, 2017.

5) You testified that you did not provide NYSOH with any additional income documentation.

6) Your NYSOH account confirms that a notice was sent to you dated September 13, 2017 stating that your children were newly eligible to enroll in Child Health Plus at full cost because information from state and federal data sources showed that your household income was more than $98,400.00 and above the income limit for Child Health Plus premium assistance.

7) NYSOH records reflect that your 2016 adjusted gross income was $86,769.00.

8) You testified that you updated your account on September 19, 2017, and that your children's financial assistance was reinstated. Also on that date you increased your attested household income to $87,931.00.

9) NYSOH records reflect that also on September 19, 2017, that your children were found eligible for Child Health Plus with a monthly premium of $60.00 each, effective November 1, 2017.

10) You testified that you paid your children's full Child Health Plus premiums for the month of October 2017, and that you are looking for their October 2017 premium to be $60.00 each, as well as reimbursement for the extra amount that you had previously paid because they lost their premium assistance.

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.

To be eligible for CHP, 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 PHL § 2511(2)(a)-(e)).

A child who meets the eligibility requirements for CHP may be eligible to have a subsidized premium payment if the child resides in a household with a household income at or below 400% of the applicable federal poverty level (FPL) (New York Public Health Law (NY PHL) § 2511(2)(a)(iii)).

NYSOH is required to verify the eligibility of an applicant for CHP subsidy payments, which includes verifying the applicant's household income. If NYSOH is unable to verify the applicant's household income using available data sources, then NYSOH must request additional information from the applicant. NYSOH must provide the applicant with a reasonable time to furnish such information (42 CFR § 457.380; 42 CFR § 435.952(c)).

Level of CHP Premiums

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% to 400% of the FPL, premiums range from $9.00 per month to $60.00 per month; over 400%, premiums are unsubsidized (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 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 is $28,440.00 for a five-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 Child Health Plus plan at full cost, effective October 1, 2017.

You filed an application for financial assistance with the cost of health insurance on July 7, 2017. As a result, your children were found eligible to enroll in Child Health Plus with a $45.00 monthly premium each. You were notified of this eligibility in a notice dated July 8, 2017. The notice also informed you that your children’s eligibility was for a limited time only, and that you needed to submit documentation of your household income by September 5, 2017.

NYSOH is required to verify the eligibility of an applicant for Child Health Plus subsidy payments, which includes verifying the applicant’s household income. If NYSOH is unable to verify the applicant’s household income using available data sources, then NYSOH must request additional information from the applicant. NYSOH must provide the applicant with a reasonable time to furnish such information.

NYSOH could not verify the income information listed in your July 7, 2017 application, so you were asked to provide documentation of your household income, and you were given 60 days from the date of your application to do so.

You testified, and your NYSOH account reflects, that you uploaded income documentation on July 7, 2017 consisting of your 2016 federal tax return.

On July 11, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the income listed in your application. The notice directed you to provide proof of income by September 5, 2017.

You testified that you did not provide NYSOH with any additional income documentation.

Your NYSOH account reflects that NYSOH redetermined your children’s eligibility on September 12, 2017, and determined that your children were eligible to enroll

in Child Health Plus at full cost, effective October 1, 2017, because information from state and federal data sources showed that your household income was more than $98,400.00 and above the income limit for Child Health Plus premium assistance.

NYSOH issued an enrollment confirmation notice on September 13, 2017 showing that your children were now enrolled in their Child Health Plus plan with a monthly premium of $192.39 each, as of October 1, 2017.

Your NYSOH account reflects that you then updated your application on September 19, 2017, increasing your household income to $87,925.31, resulting in your children's Child Health Plus monthly premium being $60.00 each.

You testified that you paid their full cost premium for October 2017, but would like to be reimbursed for the amount you had to pay in excess of $60.00 for each child.

As there is sufficient evidence that your 2017 household income was $87,925.31, it is determined that and your children incorrectly lost their financial assistance for the month of October 2017.

For these reasons, the September 13, 2017 eligibility determination is RESCINDED.

The September 13, 2017 enrollment confirmation notice is MODIFIED to state that your children were enrolled in their CHP plan with a $60.00 monthly premium each, for October 2017.

Decision

The September 13, 2017 eligibility determination is RESCINDED.

The September 13, 2017 enrollment confirmation notice is MODIFIED to state that your children were enrolled in their CHP plan with a $60.00 monthly premium each, for October 2017.

Effective Date of this Decision: December 7, 2017

How this Decision Affects Your Eligibility

Your children should not have lost their Child Health Plus premium assistance in the month of October 2017.

Your case is being sent back to NYSOH to reinstate your children's Child Health Plus premium assistance for the month of October 2017, such that their Child Health Plus premium for that month is $60.00 each.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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
  PO Box 11729
  Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The September 13, 2017 eligibility determination is RESCINDED.

The September 13, 2017 enrollment confirmation notice is MODIFIED to state that your children were enrolled in their CHP plan with a $60.00 monthly premium each, for the month of October 2017.

Your children should not have lost their Child Health Plus premium assistance in the month of October 2017.

Your case is being sent back to NYSOH to reinstate your children's Child Health Plus premium assistance for the month of October 2017, such that their Child Health Plus premium for that month is $60.00 each.

Legal Authority

We are issuing this determination in accordance with 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)

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।

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).

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 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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