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

Notice of Decision

Decision Date: November 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022763

[redacted]

On November 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 1, 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 45 Code of Federal Regulation (CFR) § 155.545.

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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).

STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: November 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022763

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did New York State of Health (NYSOH) properly determine that you were eligible to purchase a qualified health plan (QHP) at full cost as of November 1, 2017?
>
> Did NYSOH properly determine that each of your children was eligible to enroll in a full price Child Health Plus plan or Child-Only QHP as of November 1, 2017?

Procedural History

On September 25, 2017, NYSOH received an update to your application for health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that you were eligible to enroll in a qualified health plan (QHP) at full cost. The preliminary determination also stated that each of your children were eligible to enroll in a Child Health Plus (CHP) plan or Child-Only QHP at full cost. The eligibility determination was effective November 1, 2017.

Also on September 25, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as the amount of financial eligibility you and your children were determined eligible to receive.

On September 26, 2017, NYSOH issued an enrollment notice confirming you and your children's enrollment in your QHP and CHP plans, respectively, as of

September 25, 2017. The notice confirmed that your family's coverage would begin effective November 1, 2017.

On October 1, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in a QHP at full cost. The preliminary determination also stated that each of your children were eligible to enroll in a CHP plan or Child-Only QHP at full cost. The eligibility determination was effective November 1, 2017.

On November 20, 2017, you had a telephone hearing with a Hearing Officer from the 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 are applying for health insurance through NYSOH for yourself and your two children.

2. According to your NYSOH account and testimony, you plan on filing a 2017 federal income tax return, with the tax status of Head of Household (with qualifying individual), and expect to claim two dependents on that return.

3. According to your September 25, 2017 NYSOH application, you attested to an annual household income of $97,692.28, which was comprised of approximately $70,000.00 you received from your prior employer, [redacted] between August 28, 2017 and December 31, 2017. You testified that these amounts were accurate.

4. Your application reflects that you do not intend to take any deductions on your 2017 tax return.

5. You testified that you believed that only income from your current employer should be counted in assessing your eligibility for financial assistance, since income you received from your previous employer preceded your initial application to NYSOH on September 22, 2017. Furthermore, the income you received at that time has already been used to maintain your household during that time.

6. You reside in [redacted]

7. You testified that through your research and conversations with NYSOH representatives, you believed that your children should be eligible for CHP at the $60.00 reduced monthly premium. You further testified that you believe you should be eligible for some form of financial assistance, including tax credits to reduce the overall cost of your monthly premium.

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

Applicable Law and Regulations

Advance Premium Tax Credit

Advance premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and (1) expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL), (2) expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is $20,160.00 for a three-person household (81 Federal Register 4036).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Child Health Plus

A child who meets the eligibility requirements for Child Health Plus (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) (New York Public Health Law (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 Public Health Law § 2511(2)(b)).

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 NY Public Health Law § 2510 et seq. and 42 USC § 1397(a)). Eligibility rules are set out in NY Public Health Law § 2511(2), as well as in the NYSDOH 2008-2012 Contract and Plan Manual.

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in CHP depends upon the child's family household income (PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL. If the family household income is 160% up to 400%, premiums range from $9.00 per month to $60.00 per month (PHL § 2510(9)(d)). If the family household income exceeds 400%, the premium is at full price per month.

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 2016 FPL, which was $20,160.00 for a three-person household (81 Fed. Reg. 4036).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to purchase a QHP at full cost as of November 1, 2017.

The application that was submitted on September 25, 2017 listed an annual household income of $97,692.28, which consisted of (1) $70,000.00 you received from your prior employer, [redacted] between August 28, 2017 and December 31, 2017. The eligibility determination relied upon that information.

You are in a three-person household. You expect to file your 2017 income taxes as head of household and will claim two dependents on that tax return.

An annual income of $97,692.28 is 484.58% of the 2016 FPL for a three-person household. At 484.58% of the FPL, NYSOH properly determined that your income exceeded 400% of the FPL, and that you were not eligible for APTC based on the information you provided to NYSOH.

You were also found ineligible for cost-sharing reductions. As a threshold matter, cost-sharing reductions are available to a person who is eligible to receive APTC. Since it was determined that you were over-income for and not eligible to receive APTC, NYSOH also properly determined that you were not eligible for cost-

sharing reductions. Therefore, NYSOH properly determined that you were eligible to enroll in a QHP at full cost as of November 1, 2017.

The second issue under review is whether NYSOH properly determined that each of your children were eligible to enroll in CHP at full cost, effective November 1, 2017.

According to the record, you expect to file your 2017 federal income tax return, with the tax status of head of household (with qualifying individual), and claim your two children as dependents. Therefore, each of your children are in a three-person household for purposes of this analysis.

A child is eligible to enroll in CHP and premium assistance if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the applicable FPL. When household income exceeds 400% of that FPL, the parents are responsible for the full price of the monthly CHP premium payment.

On the date of your application, the relevant FPL was $20,160.00 for a three-person household. Since $97,692.28 is 484.58% of the 2016 FPL, which exceeded 400% of the FPL, NYSOH properly found each of your children to be eligible for CHP at full cost.

Since the October 1, 2017 eligibility determination notice properly stated that you were eligible to enroll in a QHP at full cost and each of your children was eligible to enroll in CHP at full cost through NYSOH, it is correct and AFFIRMED.

Decision

The October 1, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 30, 2017

How this Decision Affects Your Eligibility

This decision does not change the eligibility of you and your children.

You were eligible to enroll in a QHP at full cost and ineligible for financial assistance through NYSOH as of November 1, 2017.

Each of your children was eligible to enroll in a CHP plan at full cost as of November 1, 2017.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 after the date 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 U.S. Department of Health and Human Services. This must be done within 30 days of the date of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c))

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 October 1, 2017 eligibility determination notice is AFFIRMED.

This decision does not change the eligibility of you and your children.

You were eligible to enroll in a QHP at full cost and ineligible for financial assistance through NYSOH as of November 1, 2017.

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).

Each of your children was eligible to enroll in a CHP plan at full cost as of November 1, 2017.

Legal Authority

We are sending you this notice in accordance with Federal regulation 45 CFR § 155.545(a).

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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