



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

Notice of Decision

Decision Date: March 1, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000024488

[REDACTED]

Dear [REDACTED],

On January 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 4, 2017 and November 7, 2017 eligibility determination notices.

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 and the NY State of Health 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.

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: March 1, 2018

NY State of Health Account ID: [REDACTED]
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Issues

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

Did NY State of Health (NYSOH) properly determine that your children were eligible for a full price Child Health Plus plan, effective April 1, 2017?

Did NYSOH properly determine that your children were eligible for a full price Child Health Plus plan, effective December 1, 2017?

Procedural History

On March 3, 2017, you submitted an application for financial assistance.

On March 4, 2017, NYSOH issued an eligibility determination notice stating that your children were eligible for a full price Child Health Plus plan or Child-Only qualified health plan, effective April 1, 2017.

Also on March 4, 2017, NYSOH issued a plan enrollment notice confirming your children's enrollment in a Child Health Plus plan at full cost, effective April 1, 2017.

On November 6, 2017, an application for financial assistance was run systematically on your behalf.

On November 7, 2017, NYSOH issued an eligibility determination notice, stating that your children were eligible for a full price Child Health Plus plan or Child-Only qualified health plan, effective December 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).

Also on November 7, 2017, NYSOH issued a plan enrollment notice confirming your children's enrollment in a Child Health Plus plan at full cost, effective March 1, 2017.

On November 17, 2017, you spoke to NYSOH's Account Review Unit and appealed the premium amount for your children's Child Health Plus plans for 2017.

On January 12, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to February 2, 2018, to allow you to submit supporting documents.

On January 30, 2018, you submitted supporting documentation, which was made part of the record as Appellant's Exhibit #1. The record remained open until February 2, 2018, yet nothing else was received. The record was closed that day.

Findings of Fact

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

- 1) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim three dependents on that tax return.
- 2) You are seeking financial assistance for your children in 2017.
- 3) The applications that were submitted on March 3, 2017 and November 6, 2017 listed annual household income of \$160,000.00, consisting of \$140,000.00 you earn from your employment and \$20,000.00 your spouse earns from his self-employment. You testified that this amount was not correct, but that a NYSOH representative advised that you not make any major changes to your account because there was an issue with coverage for your youngest child.
- 4) You testified that you had three employers in 2017 and believe you earned around \$80,000.00.
- 5) You submitted your three 2017 W2 forms:
 - a. [REDACTED] for a gross income of \$32,716.00
 - b. [REDACTED] for a gross income of \$16,118.90
 - c. [REDACTED] for a gross income of \$25,208.20
- 6) You testified that your spouse earns around \$33,800.00 in self-employment income.

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- 7) You submitted a December 2017 bank statement for [REDACTED] as proof of self-employment income for your spouse.
- 8) Your application states that you will not be taking any deductions on your 2017 tax return, but you testified that you will be taking student loan interest deductions and that your spouse takes business expense deductions.
- 9) According to your NYSOH account, your application for financial assistance was updated on November 16, 2017, and your children were redetermined eligible to enroll in Child Health Plus with a \$60.00 monthly premium each, effective January 1, 2018. Your children were also enrolled in a Child Health Plus plan, effective January 1, 2018, with \$60.00 monthly premiums each. This finding is not in dispute.

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

Applicable Law and Regulations

Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

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)).

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 \$45.00 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 300% 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 month per family (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 March 3, 2017 and November 6, 2017

applications, that was the 2017 FPL, which was \$28,780.00 for a five-person household (82 Federal Register 8831).

Legal Analysis

The first issue under review is whether your appeal of NYSOH's March 4, 2017 eligibility determination notice was timely.

The 2017 premium payments for your children's Child Health Plus coverage were determined in the March 4, 2017 eligibility determination notice. The record reflects that you first contacted NYSOH regarding the premium amount for your children's Child Health Plus coverage in 2017 on November 17, 2017, when you formally requested an appeal seeking reimbursement of your premium payments for the year.

Individual applicants and enrollees must request a hearing within sixty (60) days of the due date of their notice of eligibility determination by NYSOH. For an appeal to have been valid on the issue of the premium amount for your children's Child Health Plus coverage, an appeal should have been filed by May 3, 2017. The record reflects that you filed a formal appeal on November 17, 2017, which is well outside the 60-day deadline for an appeal to be timely.

Therefore, as there has been no timely appeal of the March 4, 2017 eligibility determination notice, your appeal of the premium amounts referenced within that eligibility determination notice is **DISMISSED**.

The second issue under review is whether NYSOH properly determined that your children were eligible for a full price Child Health Plus plan, effective December 1, 2017.

The application that was submitted on November 6, 2017, listed an annual household income of \$160,000.00 and the eligibility determination relied upon that information. Although you testified that this amount was incorrect and submitted sufficient documentation to show that you earned \$74,043.10 in 2017, you did not provide sufficient documentation to prove your spouse's income. The bank statement you provided does not show a breakdown of income and expenses for his self-employment. Therefore, there is insufficient evidence in the record to recalculate your household's expected income as of November 6, 2017. Therefore, NYSOH properly relied on an annual income of \$160,000.00 as listed in your application to determine your children's eligibility.

According to the record and your testimony, you expect to file your 2017 tax return as married filing jointly and claim your children as dependents. Therefore, your children are in a five-person household for purposes of this analysis.

A child is eligible to enroll in Child Health Plus if they meet the non-financial requirements, and there is no indication in the record that your children did not meet those requirements. A child who meets the eligibility requirements for Child Health Plus 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 FPL and are not eligible for Medicaid. On the date of your application, the relevant FPL was \$28,780.00 for a five-person household. Since \$160,000.00 is 555.94% of the 2017 FPL, which far exceeds the 400% maximum limit to be eligible for a subsidy, NYSOH properly found your children to be eligible for Child Health Plus with a full price premium, effective December 1, 2017.

Since the November 7, 2017 eligibility determination notice properly stated that, based on the information in the record, your children were eligible for full price Child Health Plus, it is correct and is AFFIRMED.

Decision

Your appeal of the March 4, 2017 eligibility determination notice is untimely and, therefore, is DISMISSED.

The November 7, 2017 eligibility determination notice is AFFIRMED.

This DECISION does not affect any eligibility determinations or enrollments made after November 7, 2017.

Effective Date of this Decision: March 1, 2018

How this Decision Affects Your Eligibility

Your children were properly determined eligible for full price Child Health Plus in 2017.

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.

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).

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

Your appeal of the March 4, 2017 eligibility determination notice is untimely and, therefore, is DISMISSED.

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).

The November 7, 2017 eligibility determination notice is AFFIRMED.

Your children were properly determined eligible for full price Child Health Plus in 2017.

This DECISION does not affect any eligibility determinations or enrollments made after November 7, 2017.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerε kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 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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