



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

## Notice of Decision

Decision Date: March 23, 2018

NY State of Health Account ID [REDACTED]  
Appeal Identification Number: AP000000025549

[REDACTED]

Dear [REDACTED],

On February 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 19, 2017 and November 28, 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 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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## Decision

Decision Date: March 23, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000025549



## 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 oldest children were eligible to enroll in Child Health Plus with a \$15.00 per month premium, effective December 1, 2017?

## Procedural History

On October 18, 2017, NYSOH received your household's application for financial assistance with health insurance.

On October 19, 2017, NYSOH issued an eligibility determination notice stating, in part that your two oldest children were eligible to enroll in Child Health Plus with a \$15.00 monthly premium, effective December 1, 2017 and that their current coverage would end as of November 30, 2017.

Also on October 19, 2017, NYSOH issued an enrollment confirmation notice stating that your two oldest children were enrolled in a Child Health Plus plan with a \$15.00 premium, effective December 1, 2017.

On November 28, 2017, NYSOH issued an eligibility determination notice stating, in part that your two oldest children were eligible to enroll in Child Health Plus with a \$15.00 monthly premium, effective January 1, 2018.

On December 8, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your two oldest children were eligible for coverage through Child Health Plus at a \$15.00 per month premium.

On February 13, 2018, 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) You testified that you expect to file your 2018 tax return with a tax filing status of married filing jointly. You will claim your four children as dependents on that tax return.
- 2) The applications that were submitted on October 18, 2017 and November 27, 2017 listed annual household income of \$53,000.00, consisting of \$0.00 you earn from your employment and \$53,000.00 that your spouse earns from his employment. You testified that this amount was correct.
- 3) At the time of your applications, your two oldest children were [REDACTED]
- 4) Your application states and you testified that you will not be taking any deductions on your 2018 tax return.

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

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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 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 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 was \$32,960.00 for a six-person household (82 Federal Register 8831, 8832).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that your two oldest children were eligible to enroll in Child Health Plus with a \$15.00 per month premium.

On October 19, 2017 and on November 28, 2017, NYSOH issued eligibility determination notices stating that your two oldest children were eligible to enroll in Child Health Plus with a \$15.00 per month monthly premium.

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According to the record, you expect to file a joint federal income tax return with your spouse and claim your four children as dependents. Therefore, your two oldest children are each in a six-person household.

In your October 18, 2017 and November 27, 2017 applications, you attested to an expected household income of \$53,000.00. The application also stated that your two oldest children were [REDACTED] at the time of the application. NYSOH relied upon this information.

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 \$32,960.00 for a six-person household. Since \$53,000.00 is 160.80% of the 2017 FPL, your two oldest children should have been eligible to enroll in Child Health Plus with a \$9.00 per month premium.

Therefore, the October 19, 2017 and November 27, 2017 eligibility determination notices are RESCINDED because they improperly found your two oldest children eligible for Child Health Plus with a \$15.00 per month premium.

Your case is RETURNED to NYSOH to determine your two oldest children eligible to enroll in Child Health Plus plan with a \$9.00 monthly premium effective December 1, 2017 based on a household of 6 people with an annual household income of \$53,000.00.

## **Decision**

The October 19, 2017, eligibility determination notice is RESCINDED insofar as it found your two oldest children eligible for Child Health Plus with a \$15.00 per month premium.

The November 28, 2017, eligibility determination notice is RESCINDED insofar as it found your two oldest children eligible for Child Health Plus with a \$15.00 per month premium.

Your case is RETURNED to NYSOH to determine your two oldest children eligible to enroll in Child Health Plus plan with a \$9.00 monthly premium effective December 1, 2017 based on a household of 6 people with an annual household income of \$53,000.00.

**Effective Date of this Decision:** March 23, 2018

## **How this Decision Affects Your Eligibility**

NYSOH improperly determined your two oldest children eligible for Child Health Plus with a \$15.00 per month premium effective December 1, 2017.

Your case is being sent back to redetermine your two oldest children's eligible for \$9.00 per month Child Health plus effective December 1, 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.

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 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).

## **If You Have Questions about this Decision (Customer Service Resources):**

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- 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 19, 2017, eligibility determination notice is RESCINDED insofar as it found your two oldest children eligible for Child Health Plus with a \$15.00 per month premium.

The November 28, 2017, eligibility determination notice is RESCINDED insofar as it found your two oldest children eligible for Child Health Plus with a \$15.00 per month premium.

NYSOH improperly determined your two oldest children eligible for Child Health Plus with a \$15.00 per month premium effective December 1, 2017.

Your case is being sent back to redetermine your two oldest children's eligible for \$9.00 per month Child Health plus effective December 1, 2017.

## **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:**



## 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।

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## **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 okyerE 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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