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

Notice of Decision

Decision Date: March 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026193

[redacted]

Dear [redacted],

On March 5, 2018 you and your spouse appeared by telephone at a hearing on your appeal of NY State of Health's December 20, 2017 preliminary eligibility determination, and December 27, 2017 plan enrollment 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 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.

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

Decision

Decision Date: March 16, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026193

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NYSOH properly determine that your child was eligible to enroll in Child Health Plus at full cost, effective January 1, 2018?

Procedural History

On March 11, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for Child Health Plus with a $60.00 monthly premium, effective April 1, 2017.

Also on March 11, 2017, NYSOH issued a plan enrollment notice stating that your child was enrolled in a Child Health Plus plan with a $60.00 monthly premium, starting April 1, 2017.

On December 20, 2017, you updated your household's application for health insurance through NYSOH. That day, a preliminary determination was prepared stating that your child was eligible for Child Health Plus at full cost, beginning January 1, 2018.

On December 21, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as your child was not eligible for a $60.00 monthly premium until March 31, 2018.

On December 22, 2017, NYSOH issued an appeal confirmation notice stating the reason for your appeal was "Level of CHP premiums."

On December 27, 2017, NYSOH issued a plan enrollment notice stating that your child was enrolled in a Child Health Plus plan beginning January 1, 2018.

No corresponding eligibility determination notice was issued.

On March 5, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You appeared at that hearing with your spouse. You were both sworn in and provided testimony. 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 and your spouse testified that you are appealing your child's Child Health Plus premium increase from a $60.00 monthly premium to a full cost premium for the months of January 2018, February 2018, and March 2018.

2) Your child was enrolled into a Child Health Plus plan with a $60.00 monthly premium, effective April 1, 2017.

3) According to your NYSOH account and your collective testimony, you updated your household's application for health insurance on December 20, 2017.

4) The application submitted on December 20, 2017, listed an annual household income of $82,908.00, consisting of $48,000.00 you earn from employment, and $34,908.00 your spouse earns from employment. You and your spouse testified that that this was correct.

5) According to the December 20, 2017 application and your collective testimony, you file your tax return with a filing status of married filing jointly, and that you will claim one dependent on that tax return.

6) According to your NYSOH account and testimony, your child resides with both of you in New York County, NY.

7) You testified that, after the December 20, 2017 application was submitted, the NYSOH representative told you that your child was eligible for Child Health Plus at full cost beginning January 1, 2018.

8) You testified that the full cost premium was $260.76 per month, and that you paid the full amount to your child's Child Health Plus plan for the months of January 2018, February 2018, and March 2018.

9) Your NYSOH account does not contain a notice confirming your child's eligibility for a full cost Child Health Plus plan, beginning January 1, 2018.

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

Applicable Law and Regulations

De Novo Review

NYSOH Appeals Unit must review each appeal de novo and "consider all relevant facts and evidence adduced during the appeals process" (45 CFR § 155.535(f)). "De novo review means a review of an appeal without deference to prior decisions in the case" (45 CFR § 155.500).

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 $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 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 is $20,240.00 for a three-person household (82 Federal Register 8831).

Legal Analysis

The issue under review is whether NYSOH correctly determined that your child was enrolled in a Child Health Plus at full cost beginning January 1, 2018.

You testified that you are appealing your child's eligibility and enrollment for Child Health Plus at full cost, beginning January 1, 2018. However, the record does not contain a notice of eligibility determination regarding your child's eligibility for Child Health Plus at full cost.

The lack of a notice of eligibility determination on the issue of your child's eligibility for Child Health Plus at full cost does not prevent the Appeals Unit from reaching the merits of the case or constitute material error. Under 45 CFR § 155.505(b), you are as entitled to appeal NYSOH failure to timely issue a notice of eligibility determination as you are to appeal an adverse notice of eligibility determination.

You and your spouse credibly testified that you were told by a NYSOH representative that your child was eligible for, and enrolled in, her Child Health Plus plan as of January 2018, and that you paid the full premium payment for the months of January 2018, February 2018, and March 2018. Additionally, on December 22, 2017, NYSOH issued an appeal confirmation notice stating the reason for your appeal was "Level of CHP premiums." On December 27, 2017, NYSOH issued a plan enrollment notice reflecting a monthly premium of $260.76 starting January 1, 2018.

Based on the foregoing credible evidence, it is reasonable to conclude that NYSOH determined your child was eligible for Child Health Plus at full cost beginning January 1, 2018.

Since the Appeals Unit review of NYSOH determinations is performed on a de novo basis, no deference would have been granted to the eligibility determination notice had it been issued.

A child is eligible to enroll in Child Health Plus with a subsidy 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 above 400% of the FPL are not eligible to receive a subsidy payment.

According to the record, you and your spouse file your tax returns with a filing status as married filing jointly, and claim one dependent on your tax return. Therefore, your child is in three-person household.

The application submitted on December 20, 2017, listed an annual household income of $82,908.00. You and your spouse testified that that this was correct.

On the date of your December 20, 2017 application, the relevant FPL for a three-person household was $20,420.00. Since $82,908.00 is 406.01% of the 2017 FPL, your child would not be eligible for a Child Health Plus premium subsidy.

However, as a matter of program policy, in households with an increase in income during the coverage year, children are guaranteed their lower premium for twelve months before their premium is redetermined.

Since NYOSH originally determined your child was eligible for Child Health Plus with a $60.00 monthly premium effective April 1, 2017, this premium is effective for twelve months; that is until March 31, 2018.

Therefore, NYSOH's eligibility determination is MODIFIED to state that your child's eligibility for Child Health Plus at full cost is effective April 1, 2018.

NYSOH's December 27, 2017 plan enrollment notice is MODIFIED to state that you child's Child Health Plus $260.76 monthly premium is effective April 1, 2018.

Your case is RETURNED to NYSOH to reinstate your child's $60.00 monthly premium with her Child Health Plus plan for the months of January 2018, February 2018, and March 2018, and to Plan Management to ensure that the Child Health Plus plan records reflect that your child is enrolled with a $60.00 monthly premium for the months of January 2018, February 2018, and March 2018.

Decision

NYSOH's eligibility determination is MODIFIED to state that your child's eligibility for Child Health Plus at full cost is effective April 1, 2018.

NYSOH's December 27, 2017 notice of plan enrollment is MODIFIED to state that you child's Child Health Plus $260.76 monthly premium is effective April 1, 2018.

Your case is RETURNED to NYSOH to reinstate your child's $60.00 monthly premium with her Child Health Plus plan for the months of January 2018, February 2018, and March 2018, and to Plan Management to ensure that the Child Health Plus plan records reflect that your child is enrolled with a $60.00 monthly premium for those months.

Effective Date of this Decision: March 16, 2018

How this Decision Affects Your Eligibility

Your child remains eligible for a $60.00 monthly premium for the months of January 2018, February 2018, and March 2018.

Your case is being sent back to NYSOH to reinstate your child's $60.00 monthly premium with her Child Health Plus plan for the months of January 2018, February 2018, and March 2018. NYSOH will notify you once this has been done.

Your case is also being sent back to Plan Management to conduct outreach to your child's Child Health Plus plan to ensure premiums for those months are changed to $60.00 each.

You will need to arrange with the health plan directly the credit or reimbursement of any over-payment made those months.

Your child's monthly premium will be at full cost as of April 1, 2018.

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.

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).

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

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).

NYSOH's eligibility determination is MODIFIED to state that your child's eligibility for Child Health Plus at full cost is effective April 1, 2018.

NYSOH's December 27, 2017 notice of plan enrollment is MODIFIED to state that you child's Child Health Plus $260.76 monthly premium is effective April 1, 2018.

Your case is RETURNED to NYSOH to reinstate your child's $60.00 monthly premium with her Child Health Plus plan for the months of January 2018, February 2018, and March 2018, and to Plan Management to ensure that the Child Health Plus plan records reflect that your child is enrolled with a $60.00 monthly premium for those months.

Your child remains eligible for a $60.00 monthly premium for the months of January 2018, February 2018, and March 2018.

Your case is being sent back to NYSOH to reinstate your child's $60.00 monthly premium with her Child Health Plus plan for the months of January 2018, February 2018, and March 2018. NYSOH will notify you once this has been done.

Your case is also being sent back to Plan Management to conduct outreach to your child's Child Health Plus plan to ensure premiums for those months are changed to $60.00 each.

You will need to arrange with the health plan directly the credit or reimbursement of any over-payment made those months.

Your child's monthly premium will be at full cost as of April 1, 2018.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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।

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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 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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