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

Notice of Decision

Decision Date: May 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029057

[redacted]

Dear [redacted]

On April 30, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 2018 and February 21, 2018 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
  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: May 11, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029057

[redacted]

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 child was eligible to enroll in Child Health Plus at full cost, effective March 1, 2018?

Procedural History

On December 29, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On December 30, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for Child Health Plus (CHP) for a limited time, with a $60.00 monthly premium, effective February 1, 2018. You were requested to provide proof of your income to NYSOH by February 27, 2018 to confirm your child's eligibility.

Also on December 30, 2017, NYSOH issued an enrollment notice confirming your selection of a CHP plan for your child's enrollment as of December 29, 2017. The notice confirmed that your child's CHP plan coverage would begin effective February 1, 2018, with a $60.00 monthly premium.

On January 16, 2018, NYSOH received two earnings statements issued to you by your employer, [redacted] on December 22, 2017 and January 5, 2018.

On January 17, 2018, NYSOH redetermined your household's eligibility for financial assistance with health insurance.

On January 18, 2018, NYSOH issued an eligibility determination notice stating that your child was found eligible for CHP at full cost, effective March 1, 2018.

Also on January 18, 2018, NYSOH issued an enrollment notice confirming your child's enrollment in his CHP plan as of December 29, 2017. The notice stated that your child's enrollment in this CHP plan would continue at an increased monthly premium of $218.53, effective March 1, 2018.

On February 20, 2018, NYSOH received an update to your application for financial assistance with health insurance. In response to this application, NYSOH prepared a preliminary eligibility determination stating that your child was eligible for CHP at full cost, effective April 1, 2018.

Also on February 20, 2018, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your child was not found eligible for CHP at a $60.00 monthly premium. You were found eligible for "Aid to Continue" during the pendency of the appeal, so your child was enrolled in CHP at a $60.00 monthly premium for a limited time.

On February 21, 2018, NYSOH issued an eligibility determination notice stating that your child was found eligible for CHP at full cost, effective April 1, 2018.

On April 30, 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 head of household. You will claim your child as your sole dependent on that tax return.

2) On December 30, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for CHP for a limited time, with a $60.00 monthly premium, effective February 1, 2018. You were requested to provide proof of your income to NYSOH by February 27, 2018 to confirm your child's eligibility.

3) On January 16, 2018, NYSOH received two earnings statements issued to you by your employer, [redacted] reflecting that your Federal Taxable Income was $2,404.19 on December 22, 2017 (with a

YTD Federal Taxable Income of $66,941.13) and $2,488.97 on January 5, 2018.

4) The application updates submitted by NYSOH on January 17, 2018, and you submitted on February 20, 2018, listed annual household income of $68,335.80 and $66,000.00, respectively, each consisting solely of income you anticipate receiving from your employer, [redacted] You testified that this amount was correct.

5) At the time of your February 20, 2018 application, your child was [redacted]

6) You testified, and your NYSOH application reflects, that you will not be taking any deductions on your 2018 tax return.

7) You live in [redacted], New York.

8) You testified that you would like your child to be eligible for CHP at the $60.00 monthly premium rate.

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 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 $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 2018 FPL, which is $16,240.00 for a two-person household (83 Federal Register 2642).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (*see* 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child was eligible to enroll in Child Health Plus at full cost, effective March 1, 2018.

According to the record, you expect to file your taxes as head of household for the 2018 tax year and claim your one child as a dependent. Therefore, your child is in a two-person household.

On January 17, 2018, your eligibility was redetermined by NYSOH based on income documentation you provided on January 16, 2018, and you submitted a revised application on February 20, 2018, listed annual household income of $68,335.80 and $66,000.00, respectively, each consisting solely of income you anticipated receiving from your employer, [redacted]. The application also stated that your child is [redacted]. NYSOH relied upon this information. Furthermore, the earnings statements you provided on January 16, 2018 reflect that your federal taxable income of $66,941.13 was reasonably consistent with the updates to your application on January 16, 2018 and February 20, 2018.

A child is eligible to enroll in CHP if they meet the non-financial requirements and have a household income below 400% of the FPL.

On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $66,000.00 is 406.40% of the 2018 FPL, NYSOH properly found your child to be eligible for CHP at full cost, effective March 1, 2018.

Since the January 17, 2018 and February 21, 2018 eligibility determination notices each properly stated that your child was eligible for CHP at full cost, it is correct and is AFFIRMED.

Decision

The January 17, 2018 and February 21, 2018 eligibility determination notices are AFFIRMED.

Effective Date of this Decision: May 11, 2018

How this Decision Affects Your Eligibility

Your child remains eligible for CHP at full cost.

Your child's CHP enrollment at a $60.00 monthly premium, which was provided on a limited basis, will conclude.

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 January 17, 2018 and February 21, 2018 eligibility determination notices are AFFIRMED.

Your child remains eligible for CHP at full cost.

Your child's CHP enrollment at a $60.00 monthly premium, which was provided on a limited basis, will conclude.

Legal Authority

We are issuing this determination in accordance with 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).

A Copy of this Decision Has Been Provided To:

[redacted]

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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 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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