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

Notice of Decision

Decision Date: May 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030221

[redacted]

Dear [redacted]

On May 18, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 16, 2018 eligibility redetermination 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: May 23, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030221

[redacted]

Issue

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

> Did NY State of Health properly determine that your daughter was eligible for full-pay Child Health Plus, effective April 1, 2018?

Procedural History

On December 28, 2017, you submitted an updated application for financial assistance with health insurance through NY State of Health (NYSOH).

On December 29, 2017, NYSOH issued an eligibility redetermination notice, based on the December 28, 2017 application, stating your daughter was eligible for Child Health Plus, with a $60.00 premium per month for a limited time, effective December 1, 2017. The notice requested you provide proof of your household income by February 26, 2018 and proof of your daughter's citizenship and Social Security number by March 28, 2018.

On December 29, 2017, NYSOH issued an enrollment confirmation notice, based on a plan selection made on December 28, 2017, stating that your daughter was enrolled in a Child Health Plus plan for a cost of $60.00 per month, starting January 1, 2018.

On March 3, 2018, your eligibility for financial assistance was re-run by NYSOH.

On March 4, 2018, NYSOH issued an eligibility redetermination notice, based on the March 3, 2018 eligibility run, stating that your daughter was eligible for full-

pay Child Health Plus or a child-only qualified health plan for a limited time, effective April 1, 2018. The notice requested you provide proof of your daughter's citizenship and Social Security number by March 28, 2018.

On March 6, 2018, NYSOH issued an enrollment confirmation notice, based on an automatic plan selection made March 4, 2018, stating that your daughter was enrolled in a full-pay Child Health Plus plan, starting April 1, 2018.

On March 15, 2018, NYSOH uploaded your faxed proof of your daughter's citizenship and Social Security number to your NYSOH account. Your application was updated and your eligibility was re-run.

Also on March 15, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar as your daughter was eligible for full-pay Child Health Plus instead of Child Health Plus with a subsidized premium responsibility.

On March 16, 2018, NYSOH issued an eligibility redetermination notice, based on the March 15, 2018 eligibility run, stating that your daughter was eligible for full-pay Child Health Plus or a child-only qualified health plan for a limited time, effective April 1, 2018.

On March 16, 2018, NYSOH issued an enrollment confirmation notice, stating that your daughter was enrolled in a full-pay Child Health Plus plan, starting April 1, 2018.

On May 18, 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 and your husband expect to file your 2018 tax return with a tax filing status of married filing jointly and that you both will claim your daughter as your only dependent on that tax return.

2) The application that was submitted on March 15, 2018 listed annual household income of $82,600.00, consisting of $46,800.00 in income your husband earns from his employment, $32,500.00 in income you earn from your employment, and $3,300.00 in short-term disability income. You testified that this amount was not correct and was an overestimate of your household's expected income.

3) You testified that your husband expects to make $880.00 per week over a 52-week year, for a total of $45,760.00. You further testified that you expect to make $672.00 per week over a 36-week year due to [redacted], for a total of $24,192.00.

4) You testified that you received $550.00 per week in short-term disability payments which began the week of [redacted], for a total of six weeks.

5) Your application does not include any claimed deductions. You testified that you would pay student loan interest, but that you were not sure if it would be claimed as a deduction for 2018.

6) Your application states, and you testified, that you live in Erie County.

7) You testified that you could not understand why your daughter's health insurance had increased from the original $60.00 premium responsibility amount and that you wanted a reduced premium.

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 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 Child Health Plus premium is $60.00 per month for a child whose family household income is between 351% and 400% of the FPL (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 $20,780.00 for a three-person household (82 Fed. Reg. 2642).

Legal Analysis

The issue under review is whether NYSOH properly determined that your daughter was eligible for full-pay Child Health Plus, effective April 1, 2018.

Your daughter resides in a three-person household; you and your husband will file your 2018 tax return with a tax filing status of married filing jointly and claim your daughter as the only dependent.

On December 28, 2017, you applied for health insurance for your daughter. The result of that application was that she was determined conditionally eligible for Child Health Plus for a cost of $60.00 per month, with proof of income due by February 26, 2018 and proof of her citizenship and Social Security number due by March 28, 2018.

Your March 15, 2018 application attested to an expected household income of $82,600.00 and 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 351% and 400% of the FPL are responsible for a $60.00 per month Child Health Plus premium payment. On the date of your application, the relevant FPL was $20,780.00 for a three-person household. Since $82,600.00 is 397.50% of the 2018 FPL, your daughter should have been eligible for Child Health Plus with a $60.00 per month premium.

Therefore, the March 16, 2018 eligibility redetermination notice is RESCINDED insofar as it found your daughter eligible for full-pay Child Health Plus.

However, during the hearing, you testified that the expected annual income in your March 15, 2018 application was incorrect and based on overestimates on your part. You testified that your husband expects to have earned income of $45,760.00. You further testified that you expect to have earned income of $24,192.00. As a result, your household has an expected earned income of

$69,952.00. In addition, you received $1,650.00 in short-term disability in 2018. Therefore, according to your testimony, your total expected household income for 2018 is $73,352.00.

Since the record now contains a more accurate representation of your expected annual income for 2018, your case is RETURNED to NYSOH for a redetermination of your daughter's eligibility, based on a household of three people, using the 2018 FPL, residing in Erie County, with an expected household income of $73,352.00.

Decision

The March 16, 2018 eligibility redetermination notice is RESCINDED insofar as it found your daughter eligible for full-pay Child Health Plus.

Your case is RETURNED to NYSOH for a redetermination of your daughter's eligibility, based on a household of three people, using the 2018 FPL, residing in Erie County, with an expected household income of $73,352.00.

Effective Date of this Decision: May 23, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your daughter's eligibility for financial assistance. Your case is being sent back to NYSOH for a redetermination of your daughter's eligibility, based on a household of three people, using the 2018 FPL, residing in Erie County, with an expected household income of $73,352.00.

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 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 March 16, 2018 eligibility redetermination notice is RESCINDED insofar as it found your daughter eligible for full-pay Child Health Plus.

This is not a final determination of your daughter's eligibility for financial assistance.

Your case is RETURNED to NYSOH for a redetermination of your daughter's eligibility, based on a household of three people, using the 2018 FPL, residing in Erie County, with an expected household income of $73,352.00.

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:

[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।

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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