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

Notice of Decision

Decision Date: August 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017714

Dear [redacted],

On July 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 14, 2017 disenrollment 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.

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

Decision

Decision Date: August 23, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017714

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 youngest child, [redacted], was no longer eligible for Child Health Plus, effective February 28, 2017?

Procedural History

On November 16, 2016, NYSOH received an update to your application for health insurance.

On November 17, 2016, NYSOH issued an eligibility determination notice based on the information contained in the November 16, 2016 application. The notice stated that your youngest child was eligible for Child Health Plus (CHP), with a monthly premium of $30.00, effective January 1, 2017.

Also on November 17, 2016, NYSOH issued an enrollment notice confirming your selection of a CHP plan for your youngest child as of November 16, 2016. The notice stated that her CHP plan coverage would begin effective January 1, 2017.

On February 13, 2017, NYSOH received an update to your application for health insurance, in which you reduced your attested household income from $72,000.00 to $49,400.01.

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Also on February 13, 2017, NYSOH received three earning statements issued to your spouse by his employer, [redacted], between January 6, 2017 and February 3, 2017.

On February 14, 2017, NYSOH issued a notice stating that the February 13, 2017 application update had been reviewed, but the information contained in that application did not match what NYSOH received from state and federal data sources. The notice requested that you provide income documentation for your youngest child by February 28, 2017.

Also on February 14, 2017, NYSOH issued a disenrollment notice confirming that your youngest child's CHP coverage would end effective February 28, 2017.

On February 23, 2017, NYSOH redetermined your youngest child's eligibility based on an annual household income of $71,869.72.

On February 24, 2017, NYSOH issued an eligibility determination notice stating that your youngest child was eligible for CHP with a monthly premium of $30.00, effective April 1, 2017.

On February 25, 2017, NYSOH issued an enrollment notice confirming your selection of a CHP plan for your youngest child's enrollment as of February 24, 2017. The notice stated that your youngest child's CHP plan coverage would begin effective April 1, 2017.

On April 4, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your youngest child was terminated from her CHP enrollment as of February 28, 2017.

On July 19, 2017, 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) Your youngest child was born on [redacted]. At the time of your February 13, 2017 application, she was less than [redacted].

2) Your youngest child was initially found eligible for CHP plan coverage, effective January 1, 2017.

3) You testified, and your NYSOH account reflects, that you expect to file your 2017 tax return with a tax filing status of married filing jointly. You will claim your two children as dependents on that tax return.

4) You testified that you updated your NYSOH application on February 13, 2017, with the assistance of a NYSOH representative, to see if your monthly premiums for their CHP coverage could be reduced. You revised your application to reflect that your household income was reduced from $72,000.00 to $49,400.01, which you believe was based on an erroneous calculation reflecting that your spouse's income was $1,900.00 once every two weeks, which represented only his net income.

5) You testified that the NYSOH representative stated that your children would remain enrolled in CHP until you received a new eligibility determination notice. While your oldest child, [redacted] remained enrolled in his CHP plan with a monthly premium that was reduced from $30.00 to $9.00, your youngest child's CHP enrollment was terminated, effective February 2017.

6) On February 13, 2017, you provided to NYSOH three earning statements issued to your spouse between January 6, 2017 and February 3, 2017, each stating that your spouse was paid a gross income amount of $2,764.22 once every two weeks. His bi-weekly net income was $1,913.12.

7) On February 14, 2017, NYSOH issued a notice requesting that you provide additional income documentation by February 28, 2017 to confirm your youngest child's eligibility.

8) Your youngest child's eligibility was redetermined on March 23, 2017.

9) Your youngest child was found eligible for CHP plan coverage with a monthly premium of $30.00, effective April 1, 2017.

10) You testified that you were seeking for your youngest child's CHP plan coverage to be reinstated during the month of March 2017 since he had incurred approximately $750.00 in medical expenses during that month.

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 $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)).

Medicaid for Children

A child who is under one year of age is eligible for Medicaid if he or she meets the non-financial criteria and has a household modified adjusted gross income that falls at or below 223% of the FPL for the applicable family size. (42 CFR § 435.118(c); New York State Department of Social Services Administrative Directive 13 OHIP/ADM-03).

Legal Analysis

The issue under review is whether NYSOH properly determined that your youngest child, ████, was no longer eligible for Child Health Plus, effective February 28, 2017.

According to the record, you expect to file a joint federal income tax return for the 2017 tax year and claim your two children as dependents. Therefore, your youngest child in a four-person household.

Your youngest child was initially found eligible for CHP with a monthly premium of $30.00, effective January 1, 2017, based on your attestation of having an annual household income of $72,000.00.

On February 13, 2017, you updated your application, with the assistance of a NYSOH representative, to reflect that your annual household income was reduced from $72,000.00 to $49,400.01. The latter figure was apparently based on the net income of $1,900.00 your spouse received once every two weeks by his employer. Indeed, you provided to NYSOH three earning statements issued

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to your spouse by his employer between January 6, 2017 and February 3, 2017, which reflected bi-weekly gross income of $2,764.22 and net income of 1,913.12.

Based on the updates included in your February 13, 2017 application, your youngest child was disenrolled from CHP coverage because she had been placed in a Medicaid pending status. However, we find there is sufficient evidence that based on the earning statements provided by you on the same date you updated your application, with the assistance of a NYSOH representative, your youngest child should not have been disenrolled from her CHP coverage effective February 28, 2017. The record reflects that the earnings statements provided by you on February 13, 2017 were entirely consistent with the information you provided in your original application submitted on November 16, 2016.

Furthermore, NYSOH redetermined your youngest child eligible for CHP with a monthly premium of $30.00 based after verifying the earnings statements you provided to NYSOH on February 13, 2017.

Accordingly, since there is sufficient evidence that your youngest child was improperly disenrolled from her CHP plan coverage as of February 28, 2017, based on an incorrect household income, the February 14, 2017 disenrollment notice is RESCINDED because it is no longer supported by the record.

Your case is RETURNED to NYSOH to reinstated your youngest child's CHP plan coverage during the month of March 2017. Please note, however, that you will be responsible for all premium amounts due in connection with the reinstatement of her coverage.

Decision

The February 14, 2017 disenrollment notice is RESCINDED

Your case is RETURNED to NYSOH to reinstated your youngest child's CHP plan coverage during the month of March 2017.

Effective Date of this Decision: August 23, 2017

How this Decision Affects Your Eligibility

Your youngest child's CHP plan coverage is reinstated for the month of March 2017.

Please note, however, that you will be responsible for all premium amounts due in connection with the reinstatement of her coverage.

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 February 14, 2017 disenrollment notice is RESCINDED

Your youngest child's CHP plan coverage is reinstated for the month of March 2017.

Please note, however, that you will be responsible for all premium amounts due in connection with the reinstatement of her coverage.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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 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.

(Urdu)اردو

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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