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

Notice of Decision

Decision Date: January 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022863

[redacted]

[redacted]

On November 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 15, 2017 disenrollment and September 30, 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 and the NY State of Health 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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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).

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

Decision

Decision Date: January 12, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022863

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that your children were no longer eligible for Child Health Plus and ended their coverage, effective October 1, 2017?
>
> Did NYSOH properly determine that your children were eligible for Child Health Plus at full cost, effective November 1, 2017?
>
> Did NYSOH properly determine that you were eligible to purchase a qualified health plan (QHP) at full cost, effective November 1, 2017?

Procedural History

On June 3, 2017, NYSOH issued a renewal notice stating that based on federal and state data sources your household's eligibility had been redetermined. You qualified for a tax credit up to $0.00 per month, and your children qualified for coverage with Child Health Plus for a cost of $30.00 per month, effective August 1, 2017.

On June 18, 2017, NYSOH issued a plan enrollment notice confirming that as of June 16, 2017, your children were enrolled in a Child Health Plus plan with an enrollment start date of August 1, 2017.

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).

On September 3, 2017, NYSOH issued a disenrollment notice stating that your children's Child Health Plus coverage would end on August 31, 2017, because you did not pay your insurance bill by the payment deadline.

On September 13, 2017, your NYSOH account was updated and your household income amount was changed.

On September 14, 2017, NYSOH issued a notice stating that your September 13, 2017 application had been reviewed; however, the income information in your application did not match what NYSOH received from state and federal data sources. The notice instructed you to submit proof of household income by September 28, 2017, to confirm your household's eligibility.

Also on September 14, 2017, NYSOH issued an enrollment notice confirming that as of September 13, 2017, your children were enrolled in a Child Health Plus plan with an enrollment start date of October 1, 2017.

On September 15, 2017, NYSOH issued a disenrollment notice stating that your children's Child Health Plus coverage would end on October 1, 2017, because they were no longer eligible to enroll in that coverage.

On September 18, 2017, you faxed additional income documentation to NYSOH ([redacted]

On September 19, 2017, your NYSOH account was updated. That same day, NYSOH prepared a preliminary eligibility determination finding you eligible to purchase a qualified health plan at full cost and your children eligible to purchase a Child Health Plus plan or child-only qualified health plan at full cost.

On September 27, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance your household was determined eligible to receive.

On September 30, 2017, NYSOH issued an eligible determination notice stating that you were eligible to purchase a QHP at full cost, and your children were eligible to enroll in a full price Child Health Plus plan or a Child-Only QHP, effective as of November 1, 2017.

On November 28, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until December 12, 2017, to: (1) allow you to submit documentation of the unemployment insurance benefits that you received in 2017, and (2) allow the Hearing Officer to request the recording your September 13, 2017 conversation with NYSOH's customer service center.

On December 19, 2017, the Hearing Officer received the recording of the September 13, 2017 conversation between you and NYSOH's customer service center. That recording has been made part of the record as "Appellant Exhibit A." You did not submit any additional documentation to NYSOH's Appeals Unit. The record is now complete and closed.

Findings of Fact

A review of the record supports the following findings of fact:

1) According to your NYSOH account and testimony, you are applying for health insurance for yourself and your three children.

2) According to your NYSOH account, your children were born on: [redacted]

3) According to your NYSOH account, your children were determined eligible for Child Health Plus, with a premium of $30.00, and enrolled in a health plan, effective August 1, 2017.

4) According to your account, your children's coverage ended on August 31, 2017, because you failed to pay their premiums

5) According to your NYSOH account, you re-enrolled your children into coverage on September 13, 2017, with an October 1, 2017 enrollment start date.

6) On September 13, 2017, you contacted NYSOH's customer service center to renew your health insurance coverage (Appellant Exhibit A).

7) On September 13, 2017, you attested that your only source of income was from [redacted] and would be employed from April 7, 2017, through December 15, 2017. Further, you were paid weekly and earned on average $1,650.00 per week (Appellant Exhibit A).

8) On September 13, 2017, the NYSOH representative entered $1,000.00 as your expected yearly income in the application. Based on that update, your children were determined eligible for Medicaid, contingent on you submitting income documentation to confirm their eligibility.

9) On September 18, 2017, you submitted four weekly paystubs from [redacted]. The paystubs reflect that you were issued gross income of:

    (a) $1,936.26 on August 24, 2017;

(b) $2,310.05 on August 31, 2017;
(c) $1,245.70 on September 7, 2017;
(d) $2,297.75 on September 14, 2017;

([redacted]

10) According to your NYSOH account, on September 19, 2017, your application was updated to reflect that your expected household income was $101,266.75.

11) You testified that you received unemployment insurance benefits (UIB) from the NY State Department of Labor from December 2016 through April 7, 2017, at a gross weekly rate of $435.00.

12) According to your NYSOH account and testimony, you expect to file a 2017 federal income tax return, with the tax status of Head of Household (with qualifying individual), and expect to claim your three children as dependents on that return.

13) According to your NYSOH account, you do not expect to claim any deductions on your 2017 federal income tax return.

14) According to your NYSOH account, you and your children reside in Suffolk County, New York.

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

Applicable Law and Regulations

Child Health Plus – Continuous Coverage

The "period of eligibility" for Child Health Plus (CHP) is "that period commencing on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment on an annual basis based on all required information and documentation and ending on the last day of the twelfth month following such date" (NY Public Health Law § 2510(6)).

However, a child is not eligible for twelve months of continuous eligibility if:

- The child attains the attains the age of 19;
- The child or child's representative requests voluntary disenrollment;
- The child is no longer a resident of the state;
- The agency determines that eligibility was erroneously granted because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative;

- The child dies;
- Failure to pay required premiums or enrollment fees;
- The child becomes Medicaid eligible;
- The child has obtained other health insurance;
- The child has obtained access to a state health benefits plan subsequent to the initial/renewal period;

(*see e.g.* State Plan Amendment (SPA) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

Child Health Plus – Renewal of Financial Assistance

"A State must specify a method for determining the effective date of eligibility for [Child Health Plus], which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between [Child Health Plus] and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage," including for periodic renewals (42 CFR § 457.340(f); 42 CFR §457.343).

The eligibility of children enrolled in Child Health Plus whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months (42 CFR § 457.343; 42 CFR § 435.916(a)(1), (d)).

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)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

Household Composition

The household size equals the number of individuals for whom the taxpayers are allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

Income Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow the NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f)).

Legal Analysis

The first issue under review is whether NYSOH properly ended your children's Child Health Plus coverage as of October 1, 2017.

On September 14, 2017, NYSOH issued a plan enrollment notice confirming that as of September 13, 2017, your children were enrolled in a Child Health Plus plan with an enrollment start date of October 1, 2017.

Once a child is determined eligible for Child Health Plus, they are guaranteed 12 months of continuous coverage. This twelve-month period commences on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment. However, a child is not eligible for twelve months of continuous eligibility if the child is determined eligible for Medicaid.

On September 13, 2017, you contacted NYSOH to renew your health insurance coverage. During the conversation with a NYSOH customer service representative, you attested that your only source of income was from [redacted] and that would be employed from April 7, 2017, through December 15, 2017, with an average weekly income of $1,650.00.

The record reflects that the NYSOH representative incorrectly entered $1,000.00 as your 2017 expected yearly income. Based on the representative's error, your children were determined to be eligible for Medicaid, contingent on you submitting income documentation to confirm their eligibility.

On September 15, 2017, NYSOH issued a disenrollment notice stating that your children's Child Health Plus coverage would end on October 1, 2017, because they were no longer eligible to enroll in a Child Health Plus. Your children's coverage ended because the NYSOH representative failed to correctly enter your income in the September 13, 2017 application, which resulted in them being incorrectly eligible for Medicaid. Therefore, the September 15, 2017 disenrollment notice is RESCINDED.

The second issue under review is whether NYSOH properly determined that your children eligible to enroll in a Child Health Plus plan at full cost, effective November 1, 2017.

A child's eligibility for financial assistance toward their Child Health Plus health insurance premiums is determined once every twelve months and no more frequently. This twelve-month period is based on the effective date of their coverage.

As stated above, your children were enrolled in a Child Health Plus, with a monthly premium of $30.00, effective October 1, 2017. As discussed above, your children's eligibility for financial assistance in Child Health Plus was prematurely terminated on October 1, 2017, based on an error by a NYSOH representative that resulted in your children being incorrectly found eligible for Medicaid.

On September 18, 2017, you submitted four weekly paystubs from [redacted] ([redacted]) On September 19, 2017, used that documentation to compute your household income to be $101,266.75. Based on that computation, NYSOH determined your children eligible to enroll in Child Health Plus at full cost, effective November 1, 2017.

When your children were determined eligible for Child Health Plus at full cost, the twelve-month financial assistance eligibility period had not expired and no actual disqualifying event had occurred. Therefore, the September 30, 2017, eligibility determination notice stating that your children were eligible for Child Health Plus at full cost is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your children's Child Health Plus plan, with a $30.00 monthly premium each, as of October 1, 2017, and to notify you accordingly.

The third issue under review is whether NYSOH properly determined that you were eligible to purchase a QHP at full cost, effective November 1, 2017.

On September 13, 2017, you submitted an application for financial assistance through NYSOH. The application reflected that you attested that you expected to file a 2017 federal income tax return, with the tax status of Head of Household, and expected to claim your three children as dependents on that return. Although entered in error, the application reflected that you attested to an expected income of $1,000.00.

The income information that was entered in this application did not match federal and state data sources. As a result, on September 14, 2017, NYSOH issued a notice directing you to submit additional income documentation to confirm your eligibility. The notice issued by NYSOH directed you to submit additional

documentation that included a list of acceptable documentation, including paycheck stubs for the last 4 weeks ([redacted]

On September 18, 2017, you submitted four weekly paystubs from [redacted] The paystubs reflect that you were issued gross income of $1,936.26 on August 24, 2017; $2,310.05 on August 31, 2017; $1,245.70 on September 7, 2017; $2,297.75 on September 14, 2017 ([redacted] Using the documentation submitted, NYSOH calculated your expected household income to be ($1,936.26 + $2,310.05 + $1,245.70 + $2,297.75) X 13 periods) $101,266.75.

Your expected yearly household income was computed based on the assumption that you would be working for that employer for the entire year; however, your September 13, 2017 application reflected that you would be working at [redacted] from April 7, 2017, through December 15, 2017. Judicial notice is taken that there are 36 weeks within that timeframe. Therefore, your expected income from your employer should have been computed to be ($1,936.26 + $2,310.05 + $1,245.70 + $2,297.75) X 9 periods) $70,107.84.

You testified that you were receiving UIB from the NYS Department of Labor from December 2016 through April 7, 2017, and was receiving $435.00 per week. Judicial notice is taken that, rounding to the nearest week, there are 14 weeks between January 1, 2017, and April 7, 2017. Based on the available evidence, you were issued ($435.00 X 14 weeks) $6,090.00 in UIB in 2017. Therefore, your 2017 expected household income is ($70,107.84 + $6,090.00) $76,197.84.

The credible record reflects that NYSOH miscalculated your household income as of September 19, 2017. Therefore, the September 30, 2017, eligibility determination notice stating that you were eligible to purchase a QHP at full cost is RESCINDED.

Your case is RETURNED to NYSOH to determine your eligibility for financial assistance based on a four-person household, for an individual residing in Suffolk County, New York, with an expected household income of $76,197.84, and to notify you accordingly.

Decision

The September 15, 2017 disenrollment notice is RESCINDED.

The September 30, 2017 eligibility determination notice is RESCINDED.

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).

Your case is RETURNED to NYSOH to reinstate your children's Child Health Plus plan, with a $30.00 monthly premium each, as of October 1, 2017, and to notify you accordingly.

Your case is RETURNED to NYSOH to determine your eligibility for financial assistance based on a four-person household, for an individual residing in Suffolk County, New York, with an expected household income of $76,197.84.

Effective Date of this Decision: January 12, 2018

How this Decision Affects Your Eligibility

NYSOH improperly ended your children's Child Health Plus coverage as of October 1, 2017.

Your case is being sent back to NYSOH to reinstate your children's coverage and financial assistance as of October 1, 2017.

You will be responsible to pay for the monthly health insurance premiums to effectuate this coverage.

Your case is also being sent back to NYSOH to recalculate your eligibility for financial assistance based on the information above. NYSOH shall promptly issue you a notice of eligibility determination.

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:

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).

- 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 September 15, 2017 disenrollment notice is RESCINDED.

The September 30, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your children's Child Health Plus plan, with a $30.00 monthly premium each, as of October 1, 2017, and to notify you accordingly.

Your case is RETURNED to NYSOH to determine your eligibility for financial assistance based on a four-person household, for an individual residing in Suffolk County, New York, with an expected household income of $76,197.84. NYSOH improperly ended your children's Child Health Plus coverage as of October 1, 2017.

Your case is being sent back to NYSOH to reinstate your children's coverage and financial assistance as of October 1, 2017.

You will be responsible to pay for the monthly health insurance premiums to effectuate this coverage.

Your case is also being sent back to NYSOH to recalculate your eligibility for financial assistance based on the information above. NYSOH shall promptly issue you a notice of eligibility determination.

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।

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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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