



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

Notice of Decision

Decision Date: May 23, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015804

[REDACTED]

Dear [REDACTED]

On May 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 12, 2017 eligibility determination notice, and February 13, 2017 plan 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.

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
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Decision

Decision Date: May 23, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015804

[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 child's eligibility for and enrollment in her Child Health Plus plan with a \$45.00 monthly premium terminated effective February 28, 2017?

Procedural History

On December 7, 2016, NY State of Health (NYSOH) received your application for financial assistance with health insurance.

On December 8, 2016, NYOSH issued a notice of eligibility determination stating that your child was eligible to enroll in a Child Health Plus plan with a \$45.00 monthly premium, for a limited time, effective January 1, 2017. This notice further directed you to submit household income documentation in order to confirm your child's eligibility by February 5, 2017.

On December 9, 2016, NYSOH issued a notice confirming your child's enrollment in her Child Health Plus plan with a \$45.00 monthly premium, effective January 1, 2017.

No income documentation was received by February 5, 2017.

On February 11, 2017, NYSOH redetermined your child's eligibility for financial assistance with health insurance.

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On February 12, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for a full price Child Health Plus plan or a Child-Only qualified health plan, effective March 1, 2017.

On February 13, 2017, NYSOH issued a disenrollment notice confirming your child's disenrollment from her Child Health Plus plan with a \$45.00 monthly premium, effective February 28, 2017.

Also on February 13, 2017, you spoke with the Accounts Review Unit and appealed the eligibility determination insofar as your child was terminated from her Child Health Plus plan with a \$45.00 monthly premium as of February 28, 2017.

On May 17, 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) You testified that you are only appealing your child's Child Health Plus plan premium amount for the month of March 2017.
- 2) You testified that you do not normally elect to have electronic notices for your accounts because you very rarely check your personal e-mail account.
- 3) The record reflects that you elected to receive your correspondences from NYSOH by electronic notices.
- 4) You further testified, and your NYSOH confirms, that your personal e-mail is [REDACTED]
- 5) You testified that you did not know that you had to submit income documentation in order to confirm your child's eligibility because you never have had to do so in the past, so you thought you were "all set".
- 6) You testified that you do not recall ever checking your personal e-mail account after submitting your December 7, 2016 application, or anytime in February 2017.
- 7) You testified that you did not know that the premium amount for your child's Child Health Plus plan had changed until you received a premium bill from your child's Child Health Plus plan in February.

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

Applicable Law and Regulations

Verification Process

For all individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

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) 42 CFR § 435.952).

Electronic Notices

Applicants may choose to receive notices and information from NYSOH either by electronic alerts or by regular mail. If the applicant elects to receive electronic notices, NYSOH must send an email or other electronic communication alerting the individual that a notice has been posted to the applicant's account (42 CFR § 600.330(e); 42 CFR § 435.918(b)(4)).

Additionally, if an electronic alert regarding a notice in an individual's NYSOH account fails, NYSOH must send out the notice by regular mail within three days of the failed alert (42 CFR § 435.918(b)(5)).

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)).

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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)).

Legal Analysis

The issues under review are whether NYSOH properly determined that your child's eligibility for and enrollment in a Child Health Plus plan with a \$45.00 monthly premium terminated effective February 28, 2017.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to his or her household's projected annual income. For individuals seeking enrollment in Child Health Plus, NYSOH must request income data from federal data sources in order to verify an individual's income attestation.

If NYSOH cannot verify an individual's income documentation, it must provide the individual with notice of the inconsistency. NYSOH must then provide the individual with an opportunity to resolve the inconsistency.

In the eligibility determination notice issued on December 8, 2016, you were advised that your child was eligible for Child Health Plus with a \$45.00 monthly premium, for a limited time, effective January 1, 2017. This notice further stated that you needed to supply additional income documentation by February 5, 2017 in order to confirm your child's eligibility for financial assistance, or her financial assistance might end.

However, no income documentation was submitted in response to this notice, therefore, your child's eligibility for financial assistance was redetermined on February 11, 2017.

Subsequently, NYOSH issued an eligibility determination on February 12, 2017 which stated that your child was determined eligible to enroll in a full price Child Health Plus plan or a Child-Only qualified health plan, effective March 1, 2017. As a result, your child was found no longer eligible to enroll in a Child Health Plus plan with a \$45.00 monthly premium, and she was terminated from her current Child Health Plus plan, effective February 28, 2017.

You testified that you are unsure as to how you receive your notices from NYSOH, but you assume that you would receive your correspondents from NYSOH by regular mail because you rarely check your email. However, your NYSOH account shows that you elected to receive your notifications via

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electronic mail. You confirmed that your personal e-mail address is [REDACTED] which is the e-mail address that is listed on your NYSOH account. You testified that you do not check your personal e-mail and that you do not remember checking your e-mail after submitting your December 7, 2016 application to NYSOH.

Further, there is no evidence in the record which indicates that any electronic alert sent regarding a notice in your NYSOH account had failed. You may have failed to receive the notice because you did not check your personal e-mail; however, there is no evidence in the record that this is due to an error made by NYSOH.

Therefore, given the credible evidence in the record, it is concluded that NYSOH did give you the proper notice that you needed to submit documentation in order to ensure your child's enrollment in her Child Health Plus plan and eligibility for financial assistance would continue.

As the record reflects that NYSOH properly notified you of the need to submit income documentation and you failed to submit such documentation by the February 5, 2017 deadline, NYSOH properly determined that your child was no longer eligible for financial assistance, effective March 1, 2016 and properly terminated your child from her Child Health Plus plan with a \$45.00 monthly premium, effective February 28, 2017.

Therefore, the February 12, 2017 eligibility determination notice and February 13, 2017 plan disenrollment notice are correct and must be AFFIRMED.

Decision

The February 12, 2017 eligibility determination notice is AFFIRMED.

The February 13, 2017 plan disenrollment notice is AFFIRMED.

Effective Date of this Decision: May 23, 2017

How this Decision Affects Your Eligibility

This decision does not change your child's eligibility.

Your child was eligible for a full cost Child Health Plus plan from March 1, 2017 to March 31, 2017.

This decision has no effect on any subsequent determinations made by NYSOH.

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).

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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

This decision does not change your child's eligibility.

The February 12, 2017 eligibility determination notice is **AFFIRMED**.

The February 13, 2017 plan disenrollment notice is **AFFIRMED**.

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Your child was eligible for a full cost Child Health Plus plan from March 1, 2017 to March 31, 2017.

This decision has no effect on any subsequent determinations made by NYSOH.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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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