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

Notice of Decision

Decision Date: June 01, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000015841

[redacted]

Dear [redacted]

On May 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 31, 2016 discontinuance notice and December 31, 2016 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: June 01, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015841

[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 enrollment in his Child Health Plus plan ended effective December 31, 2016?

Procedural History

On September 30, 2016, NY State of Health (NYOSH) received your application for financial assistance with your health insurance. That day, a preliminary eligibility determination was prepared stating that your child was eligible to enroll in Child Health Plus.

On October 1, 2016, NYSOH issued a plan enrollment notice, based on your plan selection on September 30, 2016, confirming that your child was enrolled in a Child Health Plus plan with a $60.00 monthly premium, effective November 1, 2016.

On October 8, 2016, NYOSH issued an eligibility determination, based on your September 30, 2016 application, stating that your child was eligible for a Child Health Plus plan with a $60.00 monthly premium, effective November 1, 2016.

On December 31, 2016, NYSOH issued a notice of discontinuance stating that your child no longer eligible to receive health insurance through NYSOH, effective January 1, 2017, because notices regarding your child's eligibility and coverage sent to you by NYSOH were returned to the Marketplace as undeliverable. This notice also stated that you needed to update your mailing

address so that your child could remain eligible for health coverage through NYOSH.

Also on December 31, 2016, NYSOH issued a plan disenrollment notice confirming that your child's Child Health Plus coverage would end on December 31, 2016.

On February 13, 2017, NYSOH received your updated application for financial assistance with health insurance.

On February 14, 2017, NYSOH issued an eligibility determination stating that your child was eligible for a Child Health Plus plan at full cost, effective March 1, 2017.

Also on February 14, 2017, you spoke to NYSOH's Account Review Unit and appealed the disenrollment of your child from their Child Health Plus plan for the months of January and February 2017.

On February 19, 2017, NYSOH issued a plan enrollment notice, based on your February 13, 2017 plan selection, confirming your child's enrollment in a full price Child Health Plus plan, effective March 1, 2017.

On May 17, 2017, you appeared for a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The reason for the appeal, as recorded by NYSOH's Account Review Unit, was that you requested to be redetermined for financial assistance with your child's Child Health Plus plan premium payment. During the hearing, you testified that you requested the appeal because of your child's disenrollment from his Child Health Plus plan for the months of January 2017 and February 2017, and not the financial assistance you were eligible for. The Hearing Officer granted the request to amend the appeal. However, to prepare for the amended appeal, both you and the Hearing Officer mutually agreed to adjourn the hearing to May 23, 2017.

On May 23, 2017, you had an adjourned telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you requested to amend the appeal to include your child's disenrollment from his Child Health Plus plan, effective January 1, 2017. You also formally withdrew your appeal of NYSOH's February 14, 2017 eligibility determination stating that your child was eligible for a full cost Child Health Plus plan. Under oath, you waived your right to formal notice of the hearing. 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 appealing your child's disenrollment from his Child Health Plus plan, effective December 31, 2016.

2) You testified, and the record reflects, that your child was enrolled in a Child Health Plus plan with a $60.00 monthly premium, effective November 1, 2016.

3) The record indicates that your son was disenrolled from his Child Health Plus plan with a $60.00 monthly premium, effective December 31, 2016.

4) You testified that you paid your premiums to your child's Child Health Plus plan timely.

5) According to your NYSOH account, the October 1, 2016 plan enrollment notice was returned as undeliverable to NYSOH on October 26, 2016.

6) The record reflects that no other NYOSH notices were returned as undeliverable except for a plan enrollment notice dated July 29, 2016, and the October 1, 2016 plan enrollment notice.

7) The record reflects that all notices sent to you on October 1, 2016 were addressed to: [redacted].

8) You testified that this address was correct, and that you have not moved since September 2015.

9) You testified that you need to have your child's Child Health Plus plan reinstated for the months of January 2017 and February 2017 because your child has unpaid medical bills from those months.

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)).

To be eligible for enrollment in a Child Health Plus plan through the New York State of Health, one of the non-financial requirements is that the applicant must be a resident of New York State (NY Public Health Law § 2511(e)).

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 issue under review is whether NYSOH properly determined that your child's enrollment in their Child Health Plus plan with a $60.00 monthly premium ended effective December 31, 2016.

For an applicant to remain eligible for enrollment in a Child Health Plus plan through NYSOH, they must meet both the financial and non-financial requirements. One of the non-financial requirements is that the applicant must be a New York State Resident.

According to your NYSOH account, on October 1, 2016, NYSOH issued a plan enrollment notice that was returned to NYOSH as undeliverable on October 26, 2016. The returned notice was uploaded to your account on December 30, 2016.

As a result, your child was subsequently disenrolled from his Child Health Plus plan because NYOSH received mail addressed to you that was undeliverable; therefore, the system assumed that your child no longer met the state residency requirement for enrollment in a Child Health Plus plan. As such, on December 31, 2016, NYSOH issued a discontinuance notice and a plan disenrollment notice, stating that your child was no longer eligible to enroll in a Child Health

Plus plan and your child's coverage in his Child Health Plus plan would end effective December 31, 2016.

However, a review of the record reflects that this was the only notice returned as undeliverable, along with a July 29, 2016 plan enrollment notice, despite several other notices being successfully sent to the exact same address. You testified, and the record reflects, that your address is: [redacted] and that you have not moved since September 2015.

Based on the credible evidence of the record, since the October 1, 2016 notice was the only notice returned as undeliverable to NYSOH despite other notices being sent to the same mailing address, it is reasonable to conclude that this notice was returned as undeliverable through no fault of your own, and was the result of an error of the United State Postal Service. As a result, it is reasonable to conclude that your child's disenrollment from his Child Health Plus plan was in error.

Therefore, the December 31, 2016 discontinuance notice and December 31, 2016 plan disenrollment notice must be RESCINDED.

Your case is RETURNED to NYSOH to reinstate your child in his Child Health Plus plan with a $60.00 monthly premium for the months of January 2017 and February 2017, and to notify you accordingly.

Decision

The December 31, 2016 discontinuance notice is RESCINDED.

The December 31, 2016 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to effectuate the changes to your account as noted above, and to notify you accordingly.

Effective Date of this Decision: June 01, 2017

How this Decision Affects Your Eligibility

Your case is sent back to NYSOH to reinstate your child in his Child Health Plus plan with a $60.00 monthly premium for the months of January 2017 and February 2017.

NYOSH will notify you once this changes has been completed.

It is your responsibility to pay the January 2017 and February 2017 monthly premium directly to your child's Child Health Plus plan to start as of January 1, 2017.

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

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 December 31, 2016 discontinuance notice is RESCINDED.

The December 31, 2016 plan disenrollment notice is RESCINDED.

Your case is sent back to NYSOH to reinstate your child in his Child Health Plus plan with a $60.00 monthly premium for the months of January 2017 and February 2017.

NYOSH will notify you once this changes has been completed.

It is your responsibility to pay the January 2017 and February 2017 monthly premium directly to your child's Child Health Plus plan to start as of January 1, 2017.

This Decision has no effect on any subsequent eligibility 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:

[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)

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).

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।

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 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 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)

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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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