



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

## Notice of Decision

Decision Date: July 13, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016103

[REDACTED]

Dear [REDACTED]

On June 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 13, 2017 eligibility determination notice and the February 23, 2017 enrollment 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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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: July 13, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016103

[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 your children were eligible for full price Child Health Plus plan effective March 1, 2017?

Did NYSOH properly determine your children's enrollment in a \$15.00 per month each Child Health Plus plan was effective April 1, 2017?

## Procedural History

On December 8, 2016, NYSOH received your children's updated application for financial assistance.

On December 9, 2016, NYSOH issued a notice stating your two children were eligible for Child Health Plus for a limited time for a cost of \$15.00 per month each effective January 1, 2017. The notice asked that you provide proof of income by February 6, 2017. The notice stated, if you missed this deadline you may lose your insurance or receive less help paying your coverage. The income listed in your application was \$49,602.40.

Also on December 9, 2016, an enrollment notice was issued confirming your two children's enrollment on December 8, 2016 in a Child Health Plus plan for a cost of \$30.00 per month starting April 1, 2016.

Your income documentation was not received by February 6, 2017.

On February 12, 2017, NYSOH redetermined your children's eligibility for financial assistance.

On February 13, 2017, NYSOH issued a cancellation notice stating your two children's enrollment in their Child Health Plus plan would end effective February 28, 2017. The notice stated this was because they were no longer eligible to enroll in their plan.

Also on February 13, 2017, NYSOH issued a notice stating your two children were eligible for Child Health Plus at full price, effective March 1, 2017. The notice stated your children qualified for Child Health Plus at full cost because federal and state data sources show your household income was more than \$80,640.00.

On February 18, 2017, an enrollment notice was issued confirming your children's enrollment on February 12, 2017, in a full price Child Health Plus plan for a cost of \$172.08 each per month starting March 1, 2017.

On February 22, 2017, you spoke to NYSOH's Account Review Unit and appealed the level of financial assistance your children were determined eligible for effective March 1, 2017.

On February 22, 2017, NYSOH received copies of your income documentation.

On February 23, 2017, NYSOH issued a notice of eligibility based on your February 22, 2017 application stating your two children were eligible for Child Health Plus for a limited time for a cost of \$15.00 each per month, effective April 1, 2017. The notice asked that you provide proof of your income by April 23, 2017.

Also on February 23, 2017, an enrollment notice was issued stating your two children had been enrolled on February 22, 2017 in a Child Health Plus plan for a cost of \$15.00 per month each effective April 1, 2017.

On February 28, 2017, an eligibility determination notice was issued stating your children had been granted Aid to Continue through the length of your appeal effective March 1, 2017.

On February 28, 2017, an enrollment notice was issued confirming your children's enrollment in a Child Health Plus plan for a cost of \$15.00 per month each effective March 1, 2017.

On June 27, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open 15 days for you to provide proof of your household income.

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On July 7, 2017, you provided a 35-page fax including income documentation and has been incorporated into the record as (Appellant's Exhibit [REDACTED]). The record was closed upon the receipt of the requested documentation.

## Findings of Fact

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

- 1) You testified that you are only appealing your children's eligibility for the full price Child Health Plus for the month of March, 2017.
- 2) You testified that you did not receive any notice indicating you needed to provide proof of your income before February 6, 2017.
- 3) Your NYSOH account indicates you receive your notices via regular U.S. Mail.
- 4) You testified your address has not changed since initially applying for financial assistance for 2017 for your children.
- 5) No notices were returned as undeliverable in your NYSOH account.
- 6) You testified that you were not sure if you previously received all of your notices from NYSOH by regular mail.
- 7) The record supports you updated your children's application online on December 8, 2016.
- 8) You testified that you became aware that your children's Child Health Plus plan premium had increased when you received a bill from your health plan on [REDACTED].
- 9) You testified that when you became aware that your children had been redetermined for a full price Child Health Plus plan effective March 1, 2017 you contacted NYSOH to dispute the eligibility.
- 10) On February 22, 2017, NYSOH received your income documentation.
- 11) On February 22, 2017, you enrolled your children into a Child Health Plus plan for a cost of \$15.00 per month, effective April 1, 2017.

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

## Applicable Law and Regulations

### Child Health Plus

A child who meets the eligibility requirements for Child Health Plus 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 Public Health Law § 2511(2)(a)(iii)).

To be eligible for Child Health Plus, the child:

- Must be under 19 years of age;
- Must be a New York State Resident;
- Must not have other health insurance coverage; and
- Must not be eligible for, or enrolled in, Medicaid

(NY Public Health Law § 2511(2)(a)-(e)).

The “period of eligibility” for Child Health Plus 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,” unless the CHP premiums are not timely paid, or the child no longer resides in New York State, gains access to or obtains other health insurance coverage, or becomes eligible for Medicaid (NY Public Health Law § 2510(6)).

“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).

In general, a child eligible for Child Health Plus must recertify their eligibility for enrollment through NYSOH once every twelve months (42 CFR § 457.343; 42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information accessed through any data bases accessed by the agency” (NY Public Health Law § 2511(2)(f)(ii)).42 CFR § 435.916(a)(2)).

NYSOH is required to provide proper written notice to an applicant of any decision effecting an enrollee’s Child Health Plus eligibility (42 CFR §

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457.340(e)). When Child Health Plus coverage is denied, suspended or terminated NYSOH must provide sufficient notice to enable the child's parent or caretaker relative to take appropriate actions in order to allow Child Health Plus coverage to continue without interruption (42 CFR § 457.340(e)(1)(D); 42 CFR § 457.1130(a)(3)).

The State of New York has provided that a child's period of eligibility for Child Health Plus begins on the first day of the month during which a child is eligible. A child will become eligible on the first day of the next month, if the application is received by the 15th of the month; applications received after the 15th day of the month will be processed for the first day of the second following month (see State Plan Amendment (SPA) [REDACTED], approved February 3, 2015 and effective January 1, 2014).

### 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).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined your children were eligible for full price Child Health Plus plan effective March 1, 2017.

NYSOH issued an eligibility determination notice on December 9, 2016, based on your application for your two children. The determination notice stated your children were eligible for Child Health Plus for a limited time for a cost of \$15.00 per month each, effective January 1, 2017. The notice asked you to provide proof of your household income by February 6, 2017.

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.

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.

There is no record of documentation being uploaded or received by NYSOH prior to the February 6, 2017 deadline requested.

Since NYSOH did not receive the requested income documentation by the deadline, NYSOH system redetermined your children's eligibility from data sources on February 12, 2017, and determined your children were eligible to purchase a Child Health Plus plan at full cost effective, March 1, 2017.

You testified that you did not receive any notice from NYSOH telling you that you needed to update the information in your NYSOH account on your children's behalf. You testified, and your NYSOH account confirms, that you elected to receive notifications via regular mail. However, there is no evidence in the record that any of the notices that were sent to your mailing address were returned as undeliverable.

Therefore, the record reflects that NYSOH properly notified you of the need to provide income documentation to confirm the income amount in your application.

Therefore, NYSOH's February 13, 2017, eligibility determination notice stating your children were eligible to purchase a Child Health Plus plan at full cost, effective March 1, 2017, was proper and is AFFIRMED.

The second issue is whether NYSOH properly determined that your children's enrollment in their Child Health Plus plan at \$15.00 per month each was effective April 1, 2017.

You contacted NYSOH on February 22, 2017, and provided an updated application along with income documentation. The application resulted in an eligibility determination notice stating your children were eligible for a limited time to enroll in a Child Health Plus plan for a cost of \$15.00 per month each effective April 1, 2017, and you enrolled your children in a plan that day.

The date on which a Child Health Plus plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month will go into effect on the first day of the following month. A plan that is selected on or after the sixteenth day of the month will go into effect on the first day of the second following month.

Since you selected your children's plan on February 22, 2017, their plan would therefore properly take effect on the first day of the second month following February; that is, on April 1, 2017.

Therefore, the February 23, 2017, enrollment confirmation notice stating that your children's enrollment in their Child Health Plus plan at a cost of \$15.00 per

month each would be effective April 1, 2017, was correct and must be AFFIRMED.

## **Decision**

The February 13, 2017, eligibility determination notice is AFFIRMED.

The February 23, 2017, enrollment confirmation notice is AFFIRMED.

**Effective Date of this Decision:** July 13, 2017

## **How this Decision Affects Your Eligibility**

Your children were eligible for a full cost Child Health Plus plan effective March 1, 2017.

Your children were conditionally eligible for a Child Health Plus plan for a cost of \$15.00 per month each, effective April 1, 2017.

## **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:

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).

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 13, 2017, eligibility determination notice is AFFIRMED.

The February 23, 2017, enrollment confirmation notice is AFFIRMED.

Your children were eligible for a full cost Child Health Plus plan effective March 1, 2017.

Your children were conditionally eligible for a Child Health Plus plan for a cost of \$15.00 per month each, effective April 1, 2017.

### **Legal Authority**

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

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**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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