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: AP000000016562

[redacted]

Dear [redacted]

On June 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 4, 2017 eligibility redetermination 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: July 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016562

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine your child was eligible to purchase a qualified health plan at full cost effective, March 1, 2017?

Procedural History

On November 30, 2016, NY State of Health (NYSOH) received your child's application for financial assistance with her health insurance.

On December 1, 2016, NYSOH issued a notice stating your child was eligible for a limited time for Child Health Plus for a cost of $30.00 per month starting January 1, 2017. The notice asked you to provide proof of your income by January 29, 2017.

On December 1, 2016, an enrollment notice was issued confirming your child's enrollment on November 30, 2016, in a Child Health Plus plan for a cost of $30.00 per month, effective January 1, 2017.

No income documentation was received by NYSOH before January 29, 2017.

On February 4, 2017, NYSOH issued an eligibility redetermination notice stating your child's eligibility had been redetermined on February 3, 2017, and [redacted] was now eligible to enroll in a full price Child Health Plus plan, effective March 1, 2017. The notice stated this was because federal and state data sources show your household income was more than $64,080.00.

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Also on February 4, 2017, NYSOH issued a notice stating your child was enrolled in a Child Health Plus plan for a cost of $319.85 per month starting March 1, 2017.

On February 28, 2017, NYSOH received your child's updated application for financial assistance with [redacted] health insurance.

On March 1, 2017, NYSOH issued a notice stating your child was eligible for Child Health Plus for a cost of $60.00 per month, effective April 1, 2017.

Also on March 1, 2017, NYSOH issued an enrollment notice confirming your child's enrollment on February 28, 2017, in a Child Health Plus plan for a cost of $60.00 per month, effective April 1, 2017.

On March 3, 2017, you contacted the NYSOH Account Review Unit and requested an appeal of the start date of your child's Child Health Plus plan for a cost of $60.00 per month, requesting it begin March 1, 2017, not April 1, 2017.

On June 13, 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, and the record reflects, that you are appealing the level of Child Health Plus premium responsibility for the month of March, 2017.

2) You testified that at the time of your November 30, 2016 application you elected to receive your notices from NYSOH by electronic alert.

3) You testified that you did not receive any electronic alerts regarding any notice in your NYSOH account telling you that you needed to update your child's application in order to provide proof of your income by January 29, 2017.

4) You testified you switched your notification preference to regular mail notices in March, 2017 after realizing you missed the December 1, 2016 notice requesting income documentation.

5) The record reflects that you updated your child's application on February 23, 2017, and enrolled [redacted] in a Child Health Plus plan for a cost of $60.00 per month, effective April 1, 2017.

6) You testified you paid your premium responsibility for your child in advance for the entire year of 2017.

7) You testified you are seeking your child's Child Health plus premium amount for March to be redetermined at $60.00.

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

Applicable Law and Regulations

Child Health Plus

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" (42 CFR § 457.340(f)).

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 e.g.* State Plan Amendment (SPA) NY-14-0005, 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).

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)).

Legal Analysis

The issue is whether NYSOH properly determined your child was eligible for a Child Health Plus plan at full cost effective March 1, 2017.

NYSOH issued an eligibility determination notice on December 1, 2016, based on your November 30, 2016 application for financial assistance with your child's health insurance. The determination notice that was issued by NYSOH stated your child was eligible for Child Health Plus for a limited time for a cost of $30.00 per month each, effective January 1, 2017. The notice asked you to provide proof of your household income by January 31, 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.

NYSOH did not receive the requested income documentation by the stated deadline of January 31, 2017.

After not receiving the requested documentation, NYSOH redetermined your child's eligibility based on information from state and federal data sources on February 3, 2017, and redetermined that [redacted] would be eligible for a full cost Child Health Plus plan, effective March 1, 2017.

However, you testified that at the time of your initial application on November 30, 2016 you elected to receive alerts regarding notices from NYSOH electronically. You credibly testified that you did not receive any electronic alert regarding the notice that directed you to update the information in your NYSOH account. There is no evidence in your account showing that any email alert was sent to you regarding the need to renew your application, that any such electronic notice failed, or that the notice was later sent to you by regular mail.

You testified you changed your method of contact for NYSOH notifications to Regular U.S. mail after learning of your child's full price redetermination in March, 2017.

Therefore, it is concluded that NYSOH did not give you the required notice that you needed to update your account and provide proof of your income by January 29, 2017. The February 4, 2017, eligibility redetermination notice stating your child's eligibility had been redetermined on February 3, 2017, to now be eligible to enroll in a full price Child Health Plus plan, effective March 1, 2017 is RESCINDED.

Your case is RETURNED to reinstate your child' Child Health Plus plan at the newly redetermined eligibility of $60.00 per month effective March 1, 2017.

Decision

The February 4, 2017, eligibility redetermination notice finding your child eligible for a full price Child Health Plus plan effective March 1, 2017 is RESCINDED.

Your case is RETURNED to reinstate your child' Child Health Plus plan at the newly redetermined eligibility of $60.00 per month effective March 1, 2017.

Effective Date of this Decision: July 13, 2017

How this Decision Affects Your Eligibility

Your child was not eligible for a full cost Child Health Plus plan, effective March 1, 2017.

Your child's case is being returned to NYSOH to ensure [redacted] is enrolled in a Child Health Plus plan for a cost of $60.00 effective March 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:

  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):

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).

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:

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  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The February 4, 2017, eligibility redetermination notice finding your child eligible for a full price Child Health Plus plan effective March 1, 2017 is RESCINDED.

Your case is RETURNED to reinstate your child' Child Health Plus plan at the newly redetermined eligibility of $60.00 per month effective March 1, 2017.

Your child was not eligible for a full cost Child Health Plus plan, effective March 1, 2017.

Your child's case is being returned to NYSOH to ensure [redacted] is enrolled in a Child Health Plus plan for a cost of $60.00 effective March 1, 2017.

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।

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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 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)

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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