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

Notice of Decision

Decision Date: July 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017617

[redacted]

Dear [redacted],

On July 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 10, 2017 eligibility determination and disenrollment 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 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: July 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017617

[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 Child Health Plus terminated effective February 28, 2017?

Procedural History

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

On December 8, 2016, NYSOH issued a notice of eligibility determination stating that your child was eligible to enroll in Child Health Plus with a $9.00 monthly premium, for a limited time, effective January 1, 2017. The notice requested that you provide household income documentation by February 3, 2017.

Also on December 8, 2016, NYSOH issued a notice confirming your child's enrollment in a Child Health Plus plan, effective January 1, 2017.

No income documentation was received by NYSOH by February 3, 2017.

On February 10, 2017, NYSOH issued an eligibility determination notice stating that your child was newly eligible to purchase a qualified health plan at full cost through NYSOH. The notice further stated that this was because NYSOH had not received the requested income documentation within the required timeframe.

Also on February 10, 2017, NYSOH issued a disenrollment notice stating that your child's coverage in [redacted] Child Health Plus plan would end effective February 28, 2017 because [redacted] is no longer eligible to enroll in her health insurance plan.

On March 1, 2017, NYSOH received your updated application for financial assistance with health insurance.

On March 2, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible to enroll in Child Health Plus with a $9.00 monthly premium, for a limited time, effective April 1, 2017. This notice further directed you to submit income documentation by April 30, 2017.

Also on March 2, 2017, NYSOH issued an enrollment confirmation notice stating that your child was enrolled in a Child Health Plus plan, effective April 1, 2017.

On April 3, 2017, you spoke to NYSOH's Account Review Unit and appealed your child's disenrollment from [redacted] Child Health Plus plan in the month of March 2017.

On July 21, 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 disenrollment from [redacted] Child Health Plus plan for the month of March 2017.

2) You submitted an application for health insurance on December 7, 2016.

3) You testified that you were confused by the process, and were not sure what you needed to do in order to ensure that your child would be enrolled into coverage.

4) You testified that you do not recall whether you were asked for income documentation at the time you submitted your application on December 7, 2016, but if you had been you feel certain you would have provided the requested documentation.

5) You testified that you paid all the premiums for your child's Child Health Plus plan.

6) You testified, and the record reflects, that you receive all of your notices from NYSOH by regular mail.

7) You testified that you have frequent problems with receiving your mail from the United States Postal Service.

8) No notices that were sent to you at the mailing address listed in your NYSOH account have been returned as undeliverable.

9) You testified that you do not recall what made you aware that your child had been disenrolled from [redacted] Child Health Plus plan, but that you believe it was because you received a notice in the mail which caused you to update your NYSOH account.

10) You submitted an updated application for financial assistance with health insurance on March 1, 2017.

11) You testified that you enrolled your child into a Child Health Plus plan on March 1, 2017.

12) You testified that you would like your child to have continuous coverage, and to be reenrolled into [redacted] plan for the month of March 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) (New York Public Health Law (NY PHL) § 2511(2)(a)(iii)).

To be eligible for CHP, 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 PHL § 2511(2)(a)-(e)).

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)). 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)).

NYSOH is required to provide proper written notice to an applicant of any decision effecting an enrollee's Child Health Plus eligibility (42 CFR § 457.340(e)). When CHP coverage is denied, suspended, or terminated NYSOH must provide sufficient notice to enable the child's parent or caretaker relative to take appropriate actions to allow CHP coverage to continue without interruption (42 CFR § 457.340(e)(2); 42 CFR § 457.1130(a)(3)). Notice is considered received five days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the five-day period (45 CFR § 155.315(c)(3), (f)(2)(i)).

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) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child's eligibility for and enrollment in Child Health Plus terminated effective February 28, 2017.

NYSOH is required to determine whether individuals are eligible to enroll in coverage through NYSOH, and must confirm, among other things, an applicant's household 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.

The record indicates that NYSOH received your application for financial assistance with health insurance on December 7, 2016. On December 8, 2016, NYSOH issued an eligibility determination stating that your child was eligible for Child Health Plus with a $9.00 monthly premium, for a limited time, effective January 1, 2017. This notice directed you to submit household income documentation for your child by February 3, 2017.

You testified that you do not recall being asked for income documentation on December 7, 2016, but if you had been you feel certain you would have submitted the requested information. No income documentation was received by NYSOH by February 3, 2017. Subsequently, on February 9, 2017, NYSOH ran an application for financial assistance with health insurance on your child's behalf.

On February 10, 2017, NYSOH issued a disenrollment notice stating that your child's coverage in [redacted] Child Health Plus plan would end effective February 28, 2017 because [redacted] was no longer eligible to be enrolled in [redacted] Child Health Plus plan. According to the eligibility determination issued on that day, this was because NYSOH did not receive the income documentation needed to verify the income listed in your December 7, 2016 application.

When NYSOH denies, terminates, or suspends a child's Child Health Plus coverage, they are required to provide sufficient notice so that a child's parent is able to take action to prevent a gap in coverage for the child. Notice is considered received five days after the date on the notice. In this case, the notice formally disenrolling your children from [redacted] Child Health Plus plan was dated February 10, 2017. Therefore, the notice terminating your child's enrollment would be considered received as of February 15, 2017.

When changes are made to an individual's application after the 15th of any month, NYSOH must make the redetermination that results from a change effective the first day of the next following month. Since you would have received NYSOH's notice terminating your child's Child Health Plus eligibility on the 15th of the month, any changes you would have made to your account to prevent a gap in coverage would not have been effective until April 1, 2017.

Therefore, NYSOH failed to provide you with sufficient notice that would have allowed you to take action in order to prevent a gap in Child Health Plus coverage for your child for the month of March 2017 and the February 10, 2017 eligibility determination and disenrollment notices are RESCINDED.

Decision

The February 10, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is RETURNED to NYSOH to reinstate your child into [redacted] Child Health Plus plan for the month of March 2017.

Effective Date of this Decision: July 27, 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).

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate your child into [redacted] Child Health Plus for the month of March 2017.

You will be responsible for any premium payments for the months your child is enrolled into coverage.

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 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 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 10, 2017 eligibility determination and disenrollment notices are RESCINDED.

Your case is being sent back to NYSOH to reinstate your child into [redacted] Child Health Plus for the months of March 2017.

You will be responsible for any premium payments for the months your child is enrolled into coverage.

Legal Authority

We are issuing this determination in accordance with 45 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).

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.

□□□□□ (Bengali)

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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.

(Urdu)اردو

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.

(Yiddish) אידיש

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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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