



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

Notice of Decision

Decision Date: August 02 ,2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000018566

[REDACTED]

Dear [REDACTED],

On July 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 13, 2017 eligibility determination notice and April 14, 2017 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
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Decision

Decision Date: August 02 ,2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000018566

[REDACTED]

Issue

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

Did NY State of Health (NYSOH) properly determine that your children were eligible to enroll in a full price Child Health Plus plan or a Child-Only qualified health plan, effective May 1, 2017, and disenrolled from their Child Health Plus plan with a \$45.00 monthly premium per child, effective April 30, 2017?

Procedural History

On February 6, 2017, you updated your household's application for financial assistance. Specifically, you added your newborn to your application.

On February 7, 2017, NYSOH issued a notice of eligibility determination, based on your February 6, 2017 application, stating that your children were eligible to enroll in Child Health Plus for a limited time with a \$45.00 monthly premium per child, effective March 1, 2017. This notice directed you to provide proof of your household's income by April 7, 2017 as well as proof of your newborn's citizenship status by May 7, 2017.

Also on February 7, 2017, NYSOH issued a notice of enrollment confirming your older child's enrollment in his Child Health Plus plan with a \$45.00 monthly premium, effective January 1, 2016, and your newborn's enrollment in her Child Health Plus plan with a \$45.00 monthly premium, effective February 1, 2017.

No income documentation was received by April 7, 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).

On April 12, 2017, NYSOH redetermined your children's eligibility for financial assistance with health insurance.

On April 13, 2017, NYSOH issued a notice of eligibility determination, based on the April 12, 2017 redetermination, stating that your children were eligible to enroll in a full price Child Health Plus plan or a Child-Only qualified health plan, effective May 1, 2017.

On April 14, 2017, NYSOH issued a disenrollment notice stating that your children's coverage with their Child Health Plus plan would end on April 30, 2017. This was because your children were no longer eligible to enroll in their Child Health Plus plan.

Also on April 14, 2017, NYSOH issued an enrollment notice stating that your children were enrolled in a full price Child Health Plus plan, effective May 1, 2017.

On April 20, 2017, you updated your household's application for financial assistance with health insurance. Specifically, you provided your newborn's social security number.

On April 21, 2017, NYSOH issued a notice of eligibility determination, based on the April 20, 2017 application, stating that your children were eligible to enroll in Child Health Plus for a limited time with a \$45.00 monthly premium per child, effective June 1, 2017. This notice directed you to provide proof of your household's income by June 19, 2017.

Also on April 21, 2017, NYSOH issued a notice of enrollment stating that your children were enrolled in their Child Health Plus plan with a \$45.00 monthly premium per child, effective June 1, 2017.

On May 1, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your children's Child Health Plus subsidy for the month of May 2017.

Also on May 1, 2017, you updated your household's application for financial assistance with health insurance. Specifically, you updated the annual household income listed in your application.

On May 2, 2017, NYSOH issued a notice of eligibility determination, based on the May 1, 2017 application, stating that your children were eligible for Child Health Plus with a \$60.00 monthly premium per child, effective June 1, 2017.

On May 2, 2017, NYSOH issued a notice of enrollment stating that your children were enrolled in their Child Health Plus plan with a \$60.00 monthly premium per child, effective June 1, 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).

On May 9, 2017, NYSOH issued a notice of eligibility determination stating that your children were eligible for Child Health Plus for a limited time, effective May 1, 2017. This was because you have been granted Aid to Continue until a decision is made on your appeal.

Also on May 9, 2017, NYSOH issued a notice of disenrollment stating that your children's enrollment with their Child Health Plus plan was ending on June 1, 2017.

Additionally, on May 9, 2017, NYSOH issued a notice of enrollment stating that your children were enrolled in a Child Health Plus plan with a \$45.00 monthly premium per child, effective May 1, 2017.

On July 27, 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) Your account reflects that you contacted NYSOH on February 6, 2017 and updated your account to reflect the birth of your newborn.
- 2) You testified, and your NYSOH account confirms, that you receive all of your notices from NYSOH by electronic mail.
- 3) You testified that you did not receive any electronic alerts notifying you of any notice in your NYSOH account stating that your children's eligibility was only conditional and that you needed to provide documentation of your income.
- 4) You testified that you did not know there was a problem with your children's coverage until you received an electronic alert which directed you to the April 13, 2017 eligibility determination and the April 14, 2017 disenrollment notice.
- 5) Your NYSOH account indicates that on April 12, 2017 your household's application was run and your children were found no longer eligible for a Child Health Plus subsidy as of April 30, 2017.
- 6) You testified, and your NYSOH account reflects, that you contacted NYSOH and updated your household's application on April 20, 2017. The record reflects that that same day you reenrolled your children into a Child Health Plus plan with a \$45.00 monthly premium per child.

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- 7) You testified that you contacted NYSOH on May 1, 2017 in order to get a further explanation as to why your children had been found ineligible for a Child Health Plus subsidy for the month of May 2017. At that time, you updated the household income listed in your application and uploaded income documentation to your account.
- 8) You testified that you are not appealing the increase in Child Health Plus premiums as of June 1, 2017, as you received a raise resulting in an increase in your income, which you believe took place in April 2017, you are only appealing the determination that your children were not eligible for a Child Health Plus subsidy for the month of May 2017. You further testified that you are seeking reimbursement for the full cost Child Health Plus premium you paid for the month of May 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

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).

Child Health Plus – Income Verification

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).

NYSOH is required to verify the eligibility of an applicant for CHP subsidy payments, which includes verifying the applicant's household income. If NYSOH is unable to verify the applicant's household income using available data sources, then NYSOH must request additional information from the applicant. NYSOH must provide the applicant with a reasonable period of time to furnish such information (42 CFR § 457.380; 42 CFR § 435.952(c)).

Child Health Plus – Proper Notice

NYSOH may not deny or terminate eligibility or reduce benefits for any individual on the basis of the information received, unless NYSOH has sought additional information from the individual and provided proper notice and hearing rights to the individual (42 CFR § 457.380(d); 42 CFR § 435.952(d)).

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)).

Appealable Issues

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Legal Analysis

The issue is whether NYSOH properly determined that your children were eligible to enroll in a full price Child Health Plus plan or a Child-Only qualified health plan, effective May 1, 2017, and disenrolled from their Child Health Plus plan with a \$45.00 monthly premium per child, effective April 30, 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).

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 a period of two months from the date notice is received to resolve the inconsistency.

In the eligibility determination issued on February 7, 2017, you were advised that your children were eligible for Child Health Plus with a \$45.00 monthly premium per child for a limited time, and that you needed to confirm your household's income before April 7, 2017.

The record reflects that NYSOH did not receive the requested income documentation before the deadline.

However, you testified, and the record reflects that you had elected to receive alerts regarding notices from NYSOH electronically. You credibly testified that you did not receive any electronic alert regarding the eligibility determination notice, which advised you that your children's eligibility was only conditional and that you needed to submit documentation to confirm your household's income. There is also no evidence in your account documenting that any email alert was sent to you regarding the need to submit documentation, nor is there any evidence that the notice was sent to you by regular mail.

Therefore, it is concluded that NYSOH did not give you the proper notice that you needed to submit documentation of your household's income in order to confirm your children's eligibility for Child Health Plus with a \$45.00 monthly premium per child.

Since you did not receive proper notice that there was an inconsistency in your NYSOH account, the April 13, 2017 eligibility determination notice and April 14, 2017 disenrollment notice, stating that your children were eligible to enroll in a full price Child Health Plus plan or a Child-Only qualified health plan are **RESCINDED**.

Your case is **RETURNED** to NYSOH to reinstate your children's coverage in their Child Health Plus plan with a \$45.00 monthly premium per child for the month of May 2017.

During the hearing, you testified that you are seeking reimbursement for the full cost Child Health Plus premium you paid for the month of May 2017.

The Appeals Unit does not have the authority to review whether an individual should be reimbursed for premiums paid to a health plan. We cannot reach the merits as to whether you are entitled to be reimbursed for those payments.

Decision

The April 13, 2017 eligibility determination is RESCINDED.

The April 14, 2017 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your children's coverage in their Child Health Plus plan with a \$45.00 monthly premium per child for the month of May 2017

Effective Date of this Decision: August 02 ,2017

How this Decision Affects Your Eligibility

NYSOH erred in terminating your children's Child Health Plus plan with a \$45.00 monthly premium per child, effective April 30, 2017, without proper notice.

Your case is being sent back to NYSOH to reinstate your children's coverage in their Child Health Plus plan with a \$45.00 monthly premium per child, for the month of May 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 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 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 April 13, 2017 eligibility determination is RESCINDED.

The April 14, 2017 disenrollment notice is RESCINDED.

NYSOH erred in terminating your children's Child Health Plus plan with a \$45.00 monthly premium per child, effective April 30, 2017, without proper notice.

Your case is RETURNED to NYSOH to reinstate your children's coverage in their Child Health Plus plan with a \$45.00 monthly premium per child for the month of May 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).

Your case is being sent back to NYSOH to reinstate your children's coverage in their Child Health Plus plan with a \$45.00 monthly premium per child, for the month of May 2017.

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 مجانًا.

বাংলা (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 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 nkyerekeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi 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.

אײִדיש (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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