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

Notice of Decision

Decision Date: September 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019671

[redacted]

Dear [redacted],

On September 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 24, 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 at the top of this notice.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 CFR § 155.545(b).

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: September 27, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019671

[redacted]

Issue

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

> Did New York State of Health (NYSOH) properly terminate your youngest child's Child Health Plus coverage, effective September 30, 2016?

Procedural History

On December 15, 2015, NYSOH issued eligibility determination notice stating in relevant part that your youngest child (child) was conditionally eligible to enroll in Child Health Plus for a cost of $30.00 per month, effective as of January 1, 2016. The notice directed you to provide additional income documentation by February 12, 2016, to confirm your child's eligibility.

Also on December 15, 2015, NYSOH issued a plan enrollment notice confirming in relevant part that your child was enrolled in the Child Health Plus plan with a plan enrollment start date of January 1, 2016.

On March 14, 2016, your account was systemically updated.

On March 15, 2016, NYSOH issued an eligibility determination stating in relevant part that your child was eligible to enroll in Child Health Plus at a cost of $45.00 per month, effective as of April 1, 2016.

Also on March 15, 2016, NYSOH issued a plan enrollment notice confirming in relevant part that your child was enrolled in the Child Health Plus with a plan enrollment start date of January 1, 2016.

On August 23, 2016, your account was updated.

On August 24, 2016, NYSOH issued a disenrollment notice stating in relevant part that your child's coverage would end, effective September 30, 2016. The notice stated that your child's coverage was ending because they were the plan's subscriber.

Also on August 24, 2016, NYSOH issued a plan enrollment notice stating that your child's Child Health Plus coverage would not begin until a plan was selected.

On October 28, 2016, your account was updated.

On October 29, 2016, NYSOH issued an eligibility determination notice stating in relevant part that your child was conditionally eligible to enroll in Child Health Plus at a cost of $30.00 per month, effective as of October 1, 2016. The notice directed you to provide additional income documentation by October 22, 2016, to confirm your child's eligibility.

Also on October 29, 2016, NYSOH issued a plan enrollment notice confirming in relevant part that your child was enrolled in the Child Health Plus plan with an enrollment start date of December 1, 2016.

On June 9, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as your child's Child Health Plus coverage was terminated September 30, 2016, resulting in a gap in coverage.

On September 20, 2017, you had a telephone hearing with a Hearing Officer from the 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) According to your NYSOH account and testimony, your child was born on [redacted]

2) You testified you are appealing the termination of that child's Child Health Plus coverage effective September 30, 2016.

3) According to your NYSOH account, on December 15, 2015, your child was enrolled in a Child Health Plus health plan, with a plan enrollment start date of January 1, 2016.

4) According to your account and testimony, on August 23, 2016, you updated your residential address from [redacted] to [redacted], having moved on [redacted]

5) According to your NYSOH account, on August 23, 2016, your child's enrollment was systemically deleted effective September 30, 2016.

6) According to your NYSOH account, on October 29, 2016, you re-enrolled your child in a Child Health Plus plan with an enrollment start date of December 1, 2016.

7) On November 8, 2016, you submitted a complaint with NYSOH's customer service. You were requesting that your child's Child Health Plus plan be reinstated for the month of October 2016 (*see* Tracking ID: [redacted]

8) You testified that during your November 8, 2016 conversation with NYSOH's Customer Service Unit, you were informed that your child's plan was terminated because you moved from [redacted] New York to [redacted], New York.

9) You testified that you incurred approximately $250.00 in medical bills in the month of October 2016, because your child was not enrolled in a health plan.

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

Applicable Law and Regulations

Timely Appeal

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

Child Health Plus

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

The “period of eligibility” for CHP 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” (NY Public Health Law § 2510(6)).

However, a child is not eligible for twelve months of continuous eligibility if:

- The child attains the attains the age of 19;
- The child or child’s representative requests voluntary disenrollment;
- The child is no longer a resident of the state;
- The agency determines that eligibility was erroneously granted because of agency error or fraud, abuse, or perjury attributed to the child or the child’s representative;
- The child dies;
- Failure to pay required premiums or enrollment fees;
- The child becomes Medicaid eligible;
- The child has obtained other health insurance;
- The child has obtained access to a state health benefits plan subsequent to the initial/renewal period;

(*see e.g.* State Plan Amendment (SPA) NY-14-0005, approved February 3, 2015 and effective January 1, 2014).

Legal Analysis

Initially, it is noted that for an appeal to have been valid on the issue of your child’s Child Health Plus coverage being terminated, an appeal should be filed within 60 days of the notice advising you of such. According to the credible evidence in the record, your appeal was filed on June 9, 2017; however, it was based on a complaint you filed in 2016, which remained unresolved as of the date of the hearing. Therefore, your June 9, 2017 appeal is deemed timely.

The issue under review turns to whether NYSOH properly terminated your child’s Child Health Plus plan, effective September 30, 2016.

On December 15, 2015, NYSOH issued eligibility notices stating that your child was conditionally eligible for and enrolled in Child Health Plus plan, effective as of January 1, 2016.

On March 15, 2016, NYSOH issued notices stating that your child was eligible for Child Health Plus, without condition, and was enrolled in Child Health Plus plan with an enrollment start date of January 1, 2016.

Generally, once a child is determined eligible for Child Health Plus, they are guaranteed 12 months of coverage. This twelve-month period commences on the first day of the month during which a child is an eligible child and enrolled or recertified for enrollment. However, a child's is ineligible for twelve months of continuous eligibility if certain events, as stated above, occur.

The record reflects that, on August 23, 2016, you updated your residential address in your account from [redacted] to [redacted]. Based on that update, your child's enrollment was systemically deleted.

Based on the available record, on November 8, 2016, you contacted NYSOH's Customer Service Unit and were informed that your child's plan was terminated because you moved from [redacted] New York to [redacted] New York.

The record reflects that your family, including your child moved from one county in New York State to another county in this state. The record further reflects that your child remained a resident of New York and none of the enumerated events occurred to disrupt [redacted] eligibility for continuous eligibility in Child Health Plus. Therefore, your child's Child Health Plus plan was incorrectly terminated, and the August 24, 2016 disenrollment notice is RESCINDED.

You testified that you want your child's Child Health Plus plan to be reinstated for the month of October 2016 because your child incurred medical expenses in that month. Your case is RETURNED to NYSOH to reinstate your child's health plan for the months of October 2016 and November 2016, and to notify you accordingly.

Decision

The August 24, 2016 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your child's health plan for the months of October 2016 and November 2016, and to notify you accordingly.

This decision does not affect any subsequent determinations or enrollments made by NYSOH.

Effective Date of this Decision: September 27, 2017

How this Decision Affects Your Eligibility

NYSOH improperly terminated your child's Child Health Plus coverage September 30, 2016.

Your child's case has been sent back to NYSOH to reinstate your child's coverage for the months of October 2016 and November 2016. NYSOH will notify you once this has been done.

You will be responsible to pay for the monthly premiums to the health plan directly to effectuate your child's coverage for those months.

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 August 24, 2016 disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your child's health plan for the months of October 2016 and November 2016, and to notify you accordingly.

This decision does not affect any subsequent determinations or enrollments made by NYSOH.

NYSOH improperly terminated your child's Child Health Plus coverage September 30, 2016.

Your child's case has been sent back to NYSOH to reinstate your child's coverage for the months of October 2016 and November 2016. NYSOH will notify you once this has been done.

You will be responsible to pay for the monthly premiums to effectuate your child's coverage for those months.

Legal Authority

We are sending you this notice in accordance with Code of Federal Regulation 45 CFR § 155.545(a).

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)

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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