



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

## Notice of Decision

Decision Date: January 11, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022693

[REDACTED]

[REDACTED]

On December 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 22, 2017 plan 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 NY State of Health 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.

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## Decision

Decision Date: January 11, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000022693

[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 enrollment in her Child Health Plus plan was effective November 1, 2017?

## Procedural History

On June 16, 2017, NY State of Health (NYSOH) received your child's initial application for financial assistance with health insurance.

On June 18, 2017, NYSOH issued an eligibility determination notice stating your child was eligible to enroll in a Child Health Plus plan with a \$9.00 monthly premium, effective August 1, 2017.

On June 18, 2017, NYSOH issued a plan enrollment notice stating you could pick a health plan for your child now.

On June 28, 2017, NYSOH issued a plan enrollment notice based on your June 27, 2017 plan selection, stating your child was enrolled in a Child Health Plus plan, with an enrollment start date of August 1, 2017.

On July 7, 2017, NYSOH received your child's updated application for financial assistance.

On July 8, 2017, NYSOH issued a notice stating the income information your application does not match what NYSOH received from state and federal data

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sources. The notice directed you to provide income documentation by July 22, 2017.

On July 8, 2017, NYSOH issued a disenrollment notice stating your child's Child Health Plus plan would end August 1, 2017. The notice stated this was because she was no longer eligible to enroll in her health plan.

On August 3, 2017, NYSOH issued an eligibility determination notice stating your child was eligible to purchase a qualified health plan at full cost, effective September 1, 2017. The notice stated your child was not eligible for Medicaid, Child Health plus, the Essential Plan or tax credits and cost-sharing reductions because information requested to verify your household income was not received by the due date.

On August 3, 2017, NYSOH issued a notice stating your child's request for Medicaid coverage retroactively for the month of June 2017 was denied. The notice stated this was because NYSOH did not receive the requested information to confirm your household income.

On September 21, 2017, NYSOH received your child's updated application for financial assistance. That day a preliminary eligibility determination was prepared finding your child eligible for Child Health Plus for a cost of \$0.00 per month, effective November 1, 2017. You enrolled your child in a plan that day with a start date of November 1, 2017.

On September 21, 2017, you spoke to NYSOH's Account Review Unit and appealed the start date of your child's Child Health Plus plan insofar as it did not begin August 1, 2017.

On September 22, 2017, NYSOH issued a plan enrollment notice, based on your plan selection on September 21, 2017, stating that your child was enrolled in a Child Health Plus plan with an enrollment start date of November 1, 2017.

On September 30, 2017, NYSOH issued an eligibility determination notice, based on your September 21, 2017 application, stating that your child was eligible to enroll in Child Health Plus with a \$0.00 monthly premium, effective November 1, 2017.

Your telephone hearing was scheduled for November 16, 2017. The hearing was adjourned to a later date due to the Hearing Officer not being available.

On December 7, 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 appealing your child's eligibility for and enrollment start date in Child Health Plus.
- 2) You submitted an application to NYSOH for financial assistance on June 16, 2017 for your child and she was found eligible for Child Health Plus for a cost of \$9.00 per month, effective August 1, 2017. You enrolled her in a plan that day with an August 1, 2017 start date.
- 3) A new application was submitted for your child on July 7, 2017. That application stated you would be filing your 2017 taxes as married filing jointly and you would be claiming two dependents on that return. You attested to an annual expected household income of \$35,776.00 your husband earns through his employer.
- 4) You testified it was not your intention to submit a new application on behalf of your child on July 7, 2017, and that you never consented to a new application being processed that day.
- 5) You testified you contacted NYSOH on July 7, 2017, to seek clarification of the start date of your child's Child Health Plus plan only.
- 6) A review of the recording of your telephone call made to NYSOH on July 7, 2017, indicates that you consented to a new application and reapplied for your child at that time. You updated your income to \$35,776.00 and your child was determined preliminarily eligible for Medicaid. The representative then discussed your responsibility to provide supporting income documentation.
- 7) According to your NYSOH account and your testimony, your child was found eligible for Child Health Plus after submitting a new application on September 21, 2017, and an enrollment request was submitted that day for a start date of November 1, 2017.
- 8) You testified that you need your child's Child Health Plus plan to begin on August 1, 2017.
- 9) Your family resides in New York County, New York.

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

## **Applicable Law and Regulations**

### Child Health Plus

To be eligible to enroll in CHP with subsidy payments, a child must not be “eligible for medical assistance”; that is, must not be eligible for Medicaid (NY Public Health Law § 2511(2)(b)).

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).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that your child’s enrollment in her Child Health Plus plan was effective November 1, 2017.

The record shows your child was determined eligible to enroll in a Child Health Plus plan at \$9.00 per month, effective August 1, 2017. You enrolled your child in a Child Health Plus plan on June 27, 2017. This enrollment was set to begin as of August 1, 2017.

A new application was submitted on behalf of your child for financial assistance over the telephone on July 7, 2017. The result of this application was a decrease in your reported annual household income, which placed your child in a pending

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Medicaid status with income documentation due by July 22, 2017. Since your child was pending Medicaid eligibility and was no longer Child Health Plus eligible, NYSOH disenrolled her from her Child Health Plus plan as of August 1, 2017.

You testified you did not intend to file a new application on July 7, 2017, and that you were only seeking clarification of your child's Child Health Plus plan. A review of the recording of the telephone call on July 7, 2017 demonstrates you consented to a new application for your child and a new eligibility was determined for her. The NYSOH representative informed you of the new change in eligibility and the request for income documentation to support your attested income in that application. Therefore, your testimony to the contrary is not credible and will not be addressed any further.

NYSOH next received your updated application for your child on September 21, 2017. She was found eligible for Child Health Plus at \$0.00 per month, effective November 1, 2017. You enrolled her in a plan that day with a November 1, 2017 enrollment start date.

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 between the first day and fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month and the end of the month goes into effect on the first day of the second following month.

Since you selected a plan for your child on September 21, 2017, which is between the sixteenth day and the end of that month, enrollment would properly take effect the first day of the second month following September 2017; that is, on November 1, 2017.

Therefore, the September 22, 2017 plan enrollment notice stating that your child's enrollment in her Child Health Plus plan was effective November 1, 2017, is correct and must be AFFIRMED.

## **Decision**

The September 22, 2017 plan enrollment notice is AFFIRMED.

**Effective Date of this Decision:** January 11, 2018

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

This decision does not change your child's eligibility or enrollment start date.

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).

The effective date of your child's Child Health Plus plan is November 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):**

You can contact us in any of the following ways:

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

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- By mail at:  
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- By fax: 1-855-900-5557

## **Summary**

The September 22, 2017 plan enrollment notice is AFFIRMED.

This decision does not change your child's eligibility or enrollment start date.

The effective date of your child's Child Health Plus plan is November 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:**



## **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)**

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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 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 b e tumi ama wo obi a okyer e 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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