



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

## Notice of Decision

Decision Date: February 15, 2018

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000024136

[REDACTED]

[REDACTED]

On February 6, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's May 26, 2017 eligibility determination and disenrollment notices, and the June 13, 21, 22, 24, 27, 2017 and November 8, 2017 eligibility determination 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 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.

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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## Decision

Decision Date: February 15, 2018

NY State of Health Number: [REDACTED]  
Appeal Identification Number: AP000000024136



## 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 middle child was eligible to purchase a qualified health plan at full cost, effective July 1, 2017?

## Procedural History

On January 5, 2017, NYSOH issued a renewal notice stating your middle child (child) was eligible for Child Health Plus for a cost of \$30.00 per month, effective March 1, 2017.

On January 18, 2017, NYSOH issued a plan enrollment notice confirming your child's enrollment in a Child Health Plus plan for a cost of \$45.00 per month, effective March 1, 2017.

On May 25, 2017, your child's eligibility was redetermined.

On May 26, 2017, NYSOH issued a notice stating your child was newly eligible to purchase a qualified health plan at full cost, effective July 1, 2017. The notice stated your child did not qualify for Child Health Plus because federal and state data sources show he was already enrolled in Medicaid, Child Health Plus, or another program.

On May 26, 2017, NYSOH issued a disenrollment notice stating your child's coverage with his Child Health Plus plan was ending June 30, 2017.

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Applications for your child were received on June 12, 20, 21, 23, 26, and November 7, 2017.

NYSOH issued eligibility determination notices based on these applications on June 13, 21, 22, 24, 27, 2017 and November 8, 2017 stating your child was eligible to purchase a qualified health plan at full cost. The notice states this was because federal and state data sources show he was already enrolled in Medicaid, Child Health Plus, or another program.

On November 7, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as your child was not eligible for Child Health Plus.

On February 6, 2018, 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) At the time of your November 7, 2017 application, your child was [REDACTED]
- 2) You testified that you are seeking to have your child to be redetermined eligible for Child Health Plus.
- 3) Your child was disenrolled from his Child Health Plus plan, effective July 1, 2017. Notices dated June 13, 21, 22, 24, 27, 2017 and November 8, 2017 state he did not qualify for Child Health Plus because federal and state data sources show he was already enrolled in Medicaid, Child Health Plus, or another program.
- 4) You testified your child is not enrolled in any third-party health insurance or public insurance including Medicaid outside of NYSOH.
- 5) Records show that on July 27, 2017, NYSOH representatives stated you needed to provide proof of the end date of your child's Child Health Plus coverage with his plan (see Incident [REDACTED]).
- 6) The record shows that on October 10, 2017, you provided a copy of a letter from Fidelis Care showing your child's enrollment in his Child Health Plus plan ended July 1, 2017. This was the plan your child was enrolled in through NYSOH [REDACTED].

- 7) Records from eMedNY show your child has not had any coverage under Medicaid, only an enrollment in Fidelis Care from March 1, 2017 through June 30, 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

Child Health Plus (CHP) is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (see New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for 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) (NY PHL § 2511(2)(a)(iii)). 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 PHL § 2511(2)(b)).

A child is not eligible for CHP subsidy payments if they have health care coverage under other health insurance (NY PHL § 2511(2)(c)).

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,” 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)).

### Verification of Minimum Essential Coverage

NYSOH must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHP, or the BHP, using information obtained by transmitting identifying information specified by HHS to HHS for verification purposes (45 CFR § 155.330(b)).

Minimum essential coverage includes most government-sponsored insurance plans such as Medicaid, Medicare, CHP, Tricare, Veterans’ Health Coverage, and eligible employer-sponsored insurance (26 USC § 5000A(f)).

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).

## Legal Analysis

The issue under review is whether NYSOH properly determined that your child was eligible to purchase a qualified health plan at full cost and not eligible for CHP, effective July 1, 2017.

A child is eligible to enroll in CHP if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. One of the additional non-financial requirements for receipt of subsidy payments for CHP is that the child not have health care coverage under other health insurance.

NYSOH is required to verify whether any applicant is eligible for minimum essential coverage other than through eligible employer-sponsored plans, Medicaid, CHP, or the BHP.

NYSOH determined your child was eligible for CHP at a cost of \$30.00 per month, effective March 1, 2017. Your child was then enrolled in a CHP plan for a cost of \$45.00 per month.

NYSOH reviewed your child's application for financial assistance on May 25, 2017, June 12, 20, 21, 23, 26, 2017, and November 7, 2017. The result of those applications was that state and federal data sources showed your child was already enrolled in Medicaid, CHP, or another program. You testified this was not true, and the only coverage your child has been enrolled in was through CHP Fidelis Care. As a result of data sources showing he had other health insurance, your child was disenrolled from his CHP plan through Fidelis Care, effective July 1, 2017.

CHP, Medicaid, and the basic health plan are considered minimum essential coverage as defined by applicable regulations. Coverage in CHP would therefore be considered other insurance for which CHP subsidy payments and enrollment would not be allowed so long as the child remains in that insurance coverage outside of the marketplace. According to the credible evidence of record, however, your child has not had any coverage under Medicaid or CHP outside NYSOH. The record supports that he was only enrolled in Fidelis Care CHP, which was initiated by application with NYSOH for the period of March 1, 2017 through June 30, 2017.

For purposes of CHP eligibility, a child is an eligible child and will remain enrolled for twelve months 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.

NYSOH representatives requested you provide proof of your child's disenrollment from his CHP plan in order to allow him to re-enroll in coverage.

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The record supports that you provided proof of his CHP disenrollment on October 10, 2017, effective July 1, 2017 ( [REDACTED] ). Therefore, NYSOH incorrectly determined your child was receiving public coverage outside of NYSOH such that he should have remained enrolled in his current CHP plan as no other triggering events occurred which would have made him no longer eligible.

Therefore, NYSOH's May 26, 2017 eligibility determination, disenrollment notice, the June 13, 21, 22, 24, 27, 2017 and November 8, 2017 eligibility determination notices stating your child was eligible to purchase a qualified health plan at full cost and not eligible for CHP or other insurance affordability programs through NYSOH, are RESCINDED in relevant part.

Your case is RETURNED to NYSOH to verify the documentation you provided showing your child was only enrolled in CHP with Fidelis Care, which was through an application with NYSOH, and to allow you to re-enroll your child in a CHP plan effective July 1, 2017. You will be responsible for any premium payments for the months your child is enrolled.

## **Decision**

The May 26 disenrollment notice, May 26, 2017 eligibility determination notice, June 13, 21, 22, 24, 27, 2017 and November 8, 2017 eligibility determination notices stating your child was eligible to purchase a qualified health plan at full cost and not eligible for CHP or other insurance affordability programs through NYSOH, are RESCINDED in relevant part.

Your case is RETURNED to NYSOH to verify the documentation you provided showing your child was only enrolled in CHP through Fidelis Care, which was through an application with NYSOH, and to allow you to enroll your child in a CHP plan effective July 1, 2017. You will be responsible for any premium payments for the months your child is enrolled.

**Effective Date of this Decision:** February 15, 2018

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

Your child was eligible to remain enrolled in CHP effective July 1, 2017.

His case is being sent back to NYSOH to be re-enrolled in Fidelis Care CHP as of July 1, 2017. NYSOH will notify you once this is completed.

## **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

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).



Albany, NY 12211

- By fax: 1-855-900-5557

## **Summary**

The May 26 disenrollment notice, May 26, 2017 eligibility determination notice, June 13, 21, 22, 24, 27, 2017 and November 8, 2017 eligibility determination notices stating your child was eligible to purchase a qualified health plan at full cost and not eligible for CHP or other insurance affordability programs through NYSOH, are RESCINDED in relevant part.

Your case is RETURNED to NYSOH to verify the documentation you provided showing your child was only enrolled in CHP through Fidelis Care, which was through an application with NYSOH, and to allow you to enroll your child in a CHP plan effective July 1, 2017. You will be responsible for any premium payments for the months your child is enrolled.

Your child was eligible to remain enrolled in CHP effective July 1, 2017.

His case is being sent back to NYSOH to be re-enrolled in Fidelis Care CHP as of July 1, 2017. NYSOH will notify you once this is completed.

## **Legal Authority**

We are sending you this notice in accordance with Code of Federal Regulation 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 مجاناً.

### 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।

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).

## **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&btumi ama wo obi a okyerε 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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