



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

Notice of Decision

Decision Date: March 1, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025996

[REDACTED]

Dear [REDACTED],

On February 21, 2018, your authorized representation appeared by telephone at a hearing on your appeal of NY State of Health's December 1, 2017 discontinuance and plan 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: March 1, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025996

[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 his Child Health Plus plan ended effective November 30, 2017?

Procedural History

On November 17, 2017, NY State of Health (NYSOH) received your child's application for financial assistance with his health insurance.

On November 18, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for a Child Health Plus plan with a \$30.00 monthly premium, effective January 1, 2018.

Also on November 18, 2017, NYSOH issued a plan enrollment notice, based on your plan selection on November 17, 2017, confirming that your child was enrolled in a Child Health Plus plan with a \$30.00 monthly premium, effective July 1, 2017.

On November 30, 2017, NYSOH issued a discontinuance notice stating that your child was no longer eligible to receive health insurance through NYSOH, effective December 1, 2017, because notices regarding your child's eligibility and coverage sent to you by NYSOH were returned as undeliverable. This notice also stated that you needed to update your mailing address so that your child could remain eligible for health coverage through NYSOH.

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Also on December 1, 2017, NYSOH issued a plan disenrollment notice confirming that your child's Child Health Plus coverage would end on November 30, 2017.

On December 18, 2017, NYSOH received your child's updated application for financial assistance with health insurance. That day, a preliminary eligibility determination was prepared stating that your child was eligible to enroll in a Child Health Plus plan with a \$30.00 monthly premium, effective February 1, 2018. You enrolled your child into a plan that day with an effective date of February 1, 2018.

Also on December 18, 2017, you spoke to NYSOH's Account Review Unit and appealed your child's disenrollment from his Child Health Plus plan insofar as it resulted in a gap in coverage for the months of December 2017 and January 2018.

On December 19, 2017, NYSOH issued an eligibility determination notice, based on your December 18, 2017 application, stating that your child was eligible for a Child Health Plus plan with a \$30.00 monthly premium, effective February 1, 2018.

Also on December 19, 2017, NYSOH issued a plan enrollment notice, based on your December 18, 2017 plan selection, confirming your child's enrollment in a Child Health Plus plan with a \$30.00 monthly premium, effective February 1, 2018.

On February 21, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, [REDACTED] acted as your authorized representative and presented testimony on your behalf. 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 authorized representative testified that you are appealing your child's disenrollment from his Child Health Plus plan, effective November 30, 2017.
- 2) According to your NYSOH account, your child was enrolled in a Child Health Plus plan with a \$30.00 monthly premium, effective July 1, 2017.
- 3) According to your NYSOH account, your son was disenrolled from his Child Health Plus plan, effective November 30, 2017, because a notice

that was sent by NYSOH via regular mail had been returned as undeliverable.

- 4) According to your NYSOH account, the November 18, 2017 eligibility determination notice was returned by regular mail as undeliverable and was received by NYSOH on November 29, 2017.
- 5) According to your NYSOH account, no other NYSOH notices were returned as undeliverable except for the November 18, 2017 eligibility determination notice.
- 6) According to your NYSOH account, all notices sent to your mailing address since May 17, 2015, including the November 18, 2017 eligibility determination notice, were addressed to: [REDACTED]
- 7) Your authorized representative testified that this address was correct and that you have lived at this address since your child started receiving Child Health Plus through NYSOH in 2015.
- 8) Your authorized representative testified that you need to have your child's Child Health Plus plan reinstated for the months of December 2017 and January 2018, because your child has unpaid medical bills from those months.

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)).

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To be eligible for enrollment in a Child Health Plus plan through the New York State of Health, one of the non-financial requirements is that the applicant must be a resident of New York State (NY Public Health Law § 2511(e)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child's family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from \$9.00 per month to \$60.00 per month (NY PHL § 2510(9)(d)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child's enrollment in their Child Health Plus plan with a \$30.00 monthly premium ended effective November 30, 2017.

For an applicant to remain eligible for enrollment in a Child Health Plus plan through NYSOH, they must meet both the financial and non-financial requirements. One of the non-financial requirements is that the applicant must be a New York State resident.

According to your NYSOH account, on November 18, 2017, NYSOH issued an eligibility determination notice that was returned by regular mail to NYSOH as undeliverable and was received by NYSOH on November 29, 2017.

As a result, your child was subsequently disenrolled from his Child Health Plus plan because NYSOH received returned mail addressed to you that was undeliverable. Therefore, the system assumed that your child no longer met the state residency requirement for enrollment in a Child Health Plus plan. As such, on December 1, 2017, NYSOH issued a discontinuance notice stating that your child was no longer qualified for health coverage through NYSOH, effective December 1, 2017. NYSOH also issued a plan disenrollment notice on December 1, 2017, stating your child's coverage in his Child Health Plus plan would end effective November 30, 2017.

However, a review of the record reflects that this was the only notice returned as undeliverable, despite several other notices being sent to the exact same address since May 17, 2015. Your authorized representative testified, and the record reflects, that your address is: [REDACTED]. Your authorized representative testified, and the record reflects, that you have not moved since your child started receiving coverage through NYSOH in 2015.

Based on the credible evidence of the record, since the November 18, 2017 eligibility determination notice was the only notice returned as undeliverable to

NYSOH despite other notices being sent to the same mailing address, it is reasonable to conclude that this notice was returned as undeliverable through no fault of your own, and was the result of an error of the United State Postal Service. As a result, it is reasonable to conclude that your child's disenrollment from his Child Health Plus plan was in error.

Therefore, the December 1, 2017 discontinuance and plan disenrollment notices must be RESCINDED.

Your case is RETURNED to NYSOH to reinstate your child in his Child Health Plus plan with a \$30.00 monthly premium for the months of December 2017 and January 2018, and to notify you accordingly.

Decision

The December 1, 2017 discontinuance notice is RESCINDED.

The December 1, 2017 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your child in his Child Health Plus plan with a \$30.00 monthly premium for the months of December 2017 and January 2018, and to notify you accordingly.

Effective Date of this Decision: March 1, 2018

How this Decision Affects Your Eligibility

Your case is being sent back to NYSOH to reinstate your child in his Child Health Plus plan with a \$30.00 monthly premium for the months of December 2017 and January 2018. NYSOH will notify you once this change has been completed.

You will be responsible for any premium payments for your child's Child Health Plus plan coverage for all months your child is enrolled into coverage.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

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.

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).

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

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 December 1, 2017 discontinuance notice is RESCINDED.

The December 1, 2017 plan disenrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your child in his Child Health Plus plan with a \$30.00 monthly premium for the months of December 2017 and January 2018, and to notify you accordingly.

Your case is being sent back to NYSOH to reinstate your child in his Child Health Plus plan with a \$30.00 monthly premium for the months of December 2017 and January 2018. NYSOH will notify you once this change has been completed.

You will be responsible for any premium payments for your child's Child Health Plus plan coverage for all months your child is enrolled into coverage.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[REDACTED]

[REDACTED]

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।

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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 nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&etumi 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.

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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