



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

## Notice of Decision

Decision Date: April 10, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000028782

[REDACTED]

[REDACTED]

On April 5, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 20, 2018 eligibility determination and 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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## Decision

Decision Date: April 10, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000028782



## 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 child was no longer eligible for Child Health Plus and properly end their coverage effective January 31, 2018?

## Procedural History

On December 2, 2017, NYSOH issued a notice stating, in relevant part, that it was time to renew your child's health insurance for the next coverage year. That notice stated that NYSOH did not have enough information from state and federal data sources to determine whether your child qualified for financial help paying for their coverage. The notice directed you to update the information in your account by January 18, 2018, or the financial assistance your child was receiving might end.

No updates were made to your account by the January 18, 2018 deadline.

On January 20, 2018, NYSOH issued an eligibility determination notice stating that, effective February 1, 2018, your child was no longer eligible for financial assistance or health insurance through NYSOH because you did not respond to the renewal notice and did not complete the renewal in the required timeframe.

Also on January 20, 2018, NYSOH issued a disenrollment notice stating that your child's health insurance coverage would end January 31, 2018, because they were no longer eligible to enroll in health insurance.

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On February 12, 2018, your NYSOH account was updated.

Also on February 12, 2018, you spoke to NYSOH's Account Review Unit and requested an appeal insofar as your child was not enrolled in health insurance coverage for the month of February 2018.

On February 13, 2018, NYSOH issued an eligibility determination notice stating that your child was eligible for Child Health Plus with a monthly premium of \$30.00, effective March 1, 2018.

Also on February 13, 2018, NYSOH issued a plan enrollment notice confirming that as of February 12, 2018, your child was enrolled in a Child Health Plus plan with an enrollment start date of March 1, 2018.

On April 5, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken and the record was fully developed during the hearing. The record was 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 not being enrolled in a Child Health Plus plan for the month of February 2018.
- 2) Your child was born on [REDACTED].
- 3) According to your NYSOH account, you receive notices from NYSOH electronically.
- 4) You testified that you did not receive any notice from NYSOH instructing you to renew your child's coverage.
- 5) You testified that you became aware that your child's coverage would end when you received the disenrollment notice from NYSOH.
- 6) According to your NYSOH account, on February 12, 2018, your child was reenrolled in a Child Health Plus plan with an enrollment start date of March 1, 2018.
- 7) You testified that your child incurred medical expenses during the month of February 2018, and want the Child Health Plus plan to cover those expenses.

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

## **Applicable Law and Regulations**

### Child Health Plus - Eligibility

A child who meets the eligibility requirements for Child Health Plus 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)).

To be eligible for Child Health Plus, the child:

- Must be under 19 years of age;
- Must be a New York State Resident;
- Must not have other health insurance coverage; and
- Must not be eligible for, or enrolled in, Medicaid

(N.Y. Pub. Health Law. § 2511(2)(a)-(e)).

### Child Health Plus - Renewal

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,” including for periodic renewals (42 CFR § 457.340(f); 42 CFR §457.343).

In general, a child eligible for Child Health Plus must recertify their eligibility for enrollment through NYSOH once every twelve months (42 CFR § 457.343; 42 CFR § 435.916(a)(1), (d)). NYSOH must make its “redetermination of eligibility without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency, including but not limited to information

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accessed through any data bases accessed by the agency” (NY Public Health Law § 2511(2)(f)(ii); 42 CFR § 435.916(a)(2)).

### Child Health Plus – Notice Requirement

NYSOH is required to provide proper written notice to an applicant of any decision effecting an enrollee’s Child Health Plus eligibility (42 CFR § 457.340(e)). When Child Health Plus coverage is denied, suspended or terminated NYSOH must provide sufficient notice to enable the child's parent or caretaker relative to take appropriate actions to allow Child Health Plus coverage to continue without interruption (42 CFR § 457.340(e)(1)(D)(ii), (iii)).

## **Legal Analysis**

The issue under review is whether NYSOH properly determined that your child was no longer eligible for Child Health Plus such that their coverage ended effective January 31, 2018.

Generally, NYSOH must redetermine a qualified child's eligibility for Child Health Plus once every twelve months without requiring information from the individual if able to do so based on reliable information contained in the individual's account or other more current information available to the agency.

NYSOH's December 2, 2017 renewal notice stated that NYSOH did not have enough information from state and federal data sources to determine whether your child qualified for financial help paying for her coverage. The notice directed you to update the information in your account by January 18, 2018. or the financial assistance your child was receiving might end. No updates were made to your NYSOH account prior to January 18, 2018.

On January 20, 2018, NYSOH issued a disenrollment notice stating that your child’s coverage in their Child Health Plus plan would end effective January 31, 2018. According to the eligibility determination issued on January 20, 2018, this was because you did not respond to the renewal notice and did not complete the renewal in the required time frame.

When NYSOH denies, terminates, or suspends a child’s Child Health Plus coverage, they are required to provide sufficient notice to enable the child's parent or caretaker relative to take appropriate actions to allow Child Health Plus coverage to continue without interruption.

When changes are made to an application, the effective date of the change is contingent on whether it was made after the 15<sup>th</sup> of the month. The January 20, 2018 notices stated that your child’s coverage was ending effective January 31, 2018. Since you received the notices after the 15<sup>th</sup> of the month, any changes

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made to your account would not have been effective until March 1, 2018, which would create a gap in coverage not prevent one.

As such, NYSOH failed to provide you with sufficient notice that would have allowed you to prevent a gap in your child's health insurance coverage.

Therefore, the January 20, 2018 eligibility determination and disenrollment notices are RESCINDED.

Your child's case is RETURNED to NYSOH to reinstate their Child Health Plus coverage for the month of February 2018, and to notify you accordingly.

## **Decision**

The January 20, 2018 eligibility determination notice is RESCINDED.

The January 20, 2018 disenrollment notice is RESCINDED.

Your child's case is RETURNED to NYSOH to reinstate their Child Health Plus coverage for the month of February 2018, and to notify you accordingly.

**Effective Date of this Decision:** April 10, 2018

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

Your child's health insurance coverage improperly ended as of January 31, 2018, without sufficient notice.

Your child's case has been returned to NYSOH to reinstate their coverage for the month of February 2018. NYSOH will notify you once this is done

You will be responsible to pay any health insurance premiums timely and directly to the health plan to effectuate your child's coverage for February 2018.

## **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

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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 January 20, 2018 eligibility determination notice is **RESCINDED**.

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The January 20, 2018 disenrollment notice is RESCINDED.

Your child's case is RETURNED to NYSOH to reinstate their Child Health Plus coverage for the month of February 2018, and to notify you accordingly.

Your child's health insurance coverage improperly ended as of January 31, 2018, without sufficient notice.

Your child's case has been returned to NYSOH to reinstate their coverage for the month of February 2018. NYSOH will notify you once this is done

You will be responsible to pay any health insurance premiums timely and directly to the health plan to effectuate your child's coverage for February 2018.

### **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 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 okyer& 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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