



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

Notice of Decision

Decision Date: May 2, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015094

[REDACTED]

Dear [REDACTED],

On April 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health’s August 9, 2016 plan 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 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).

This page intentionally left blank.



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

Decision

Decision Date: May 2, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015094



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's enrollment in his full price Child Health Plus (CHP) plan ended effective August 31, 2016?

Procedural History

On December 16, 2015, NYSOH issued a notice of eligibility determination stating that your child was eligible to enroll in a full price CHP plan, or child-only qualified health plan, effective January 1, 2016.

On December 18, 2015, NYSOH issued a notice of enrollment confirmation stating that your child was enrolled in a CHP plan with CDPHP with a monthly premium of \$233.40, and that his enrollment would begin January 1, 2016.

On August 8, 2016, you contacted NYSOH and requested to end your child's enrollment in his CHP coverage and plan.

On August 9, 2016, NYSOH issued a plan disenrollment notice confirming your child's disenrollment from his full price CHP plan, effective August 31, 2016.

On January 24, 2017, you spoke to NYSOH's Account Review Unit and appealed the date that your child was disenrolled from his full price CHP plan, requesting the disenrollment be made effective July 1, 2016.

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).

On April 24, 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) You testified that you became eligible for health insurance benefits through your employer when you switched to a new position that was part-time instead of per diem.
- 2) You testified that you found out on July 7, 2016 that you were hired for the position, and you were also told that same day that you could have benefits retroactive to July 1, 2016.
- 3) You testified that you called CDPHP because your child had full a cost CHP plan through them, and you and your spouse were enrolled in a qualified health plan through them as well.
- 4) You testified that CDPHP advised you to send a letter to them to request termination of your coverage, and you wrote this letter on July 26, 2016. You mailed a copy of this letter to NYSOH, and NYSOH uploaded it to your account on April 1, 2017 [REDACTED].
- 5) You testified that you were requesting that your coverage end on August 1, 2016, as you had already paid for your July coverage through NYSOH, and you thought you would just let the two coverages overlap for that month.
- 6) You testified that you received a call from NYSOH in August 2016 asking you to contact them. You testified that you called NYSOH on August 8, 2016 and told them that you wanted to end your and your spouse's coverage, as well as your child's coverage, effective August 1, 2016.
- 7) You testified that NYSOH informed you that they would file an incident regarding this request.
- 8) You testified that you spoke to CDPHP again in September 2016 and were informed that your and your spouse's July 2016 coverage was cancelled. You testified that you received a refund of the July 2016 premium that you paid to CDPHP for your qualified health plan.
- 9) You testified that you were also informed by CDPHP that it was "illegal" to have two insurance policies from the same company in a given month.

- 10) You testified that, in subsequent months, you kept having to follow up with NYSOH, and that it was very frustrating because they behaved as if you had only requested to terminate your qualified health plan coverage, and not your child's CHP coverage.
- 11) You testified that you did not ask CDPHP to refund your July 2016 premium payment because you believed it was out of their hands, as your qualified health plan premium payment was only refunded after you contacted NYSOH.
- 12) You testified that, to your knowledge, CDPHP has not applied the July 2016 CHP premium to any other coverage. You testified that they also have not refunded the payment to you.
- 13) You testified that you are not aware of any effort on the part of CDPHP to bill you for the August 2016 CHP premium, and that none of the statements you've received seem to indicate that they are expecting you to pay that premium.
- 14) You testified that you did not use your child's CHP coverage in either July or August 2016.
- 15) You testified that you are seeking retroactive disenrollment from your child's full price CHP plan for the months of July and August 2016 because you believe you acted in an honest and straightforward fashion and did everything you could to end your child's CHP coverage as soon as you knew that he had coverage through your employer.

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

Applicable Law and Regulations

Child Health Plus

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)).

Child Health Plus Disenrollment Date

The State plan must include a description of the state's policies governing enrollment and disenrollment (see 42 CFR § 457.305(b)). Eligibility rules are set out in NY Public Health Law § 2511(2), as well as in the NYSDOH 2008-2012 Contract and Plan Manual.

If the enrollee requests a disenrollment, the request is effective the first day of the month following the receipt of the enrollee's request or effective on a future date if requested by the enrollee (NYSDOH 2008-2012 Model Contract (Appendix C Section 12.2)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child's enrollment in his full price CHP plan ended effective August 31, 2016.

On December 16, 2015, NYSOH issued an eligibility determination notice stating that your child was eligible to enroll in a full cost CHP plan, effective January 1, 2016. Your child was subsequently enrolled into a CHP plan that also began January 1, 2016.

On August 8, 2016, you spoke to NYSOH and requested that your child be disenrolled from his CHP plan. NYSOH issued notice on August 9, 2016 stating that your child was disenrolled from his plan, effective August 31, 2016, based on your August 8, 2016 request.

You testified that you are seeking retroactive disenrollment for your child from his full price CHP plan, effective July 1, 2016 because he had coverage through your employer beginning in July 2016.

The first time you contacted NYSOH seeking your child be disenrolled from his CHP coverage was August 8, 2016. You testified that you first contacted CDPHP, (your child's CHP plan), in July to tell them that you wanted your child's coverage to be terminated, and that they did not refer you to NYSOH, but instead told you to write them a letter. You provided a copy of that letter to NYSOH, and it reflects that it was written on July 26, 2016.

You testified that you were originally seeking for your child's coverage to end as of August 1, 2016, but you were told by CDPHP, through which your family has employer-sponsored coverage, that he could not have two policies through the same insurer in a given month. You testified, and your NYSOH account reflects, that you and your spouse were permitted to have your qualified health plan coverage retroactively terminated, and that you received a refund of the premium

you paid for that coverage, so you believe that you should be able to receive a refund of the premium you paid for your child's CHP coverage as well.

Enrollees may request disenrollment from their CHP plan at any time. If the enrollee requests a disenrollment, the request is effective the first day of the month following the receipt of the enrollee's request, or effective on a future date if requested by the enrollee.

The record reflects that, though you spoke to CDPHP in July 2016, you first spoke to NYSOH to request a disenrollment on August 8, 2016. You confirmed that this was the case in your testimony. Therefore, NYSOH's August 9, 2016 disenrollment notice, stating that your child's coverage would end as of August 31, 2016, was correct and must be AFFIRMED.

You testified that CDPHP is not billing you for your child's August CHP premium, as far as you are aware, but that they have retained your July 2016 CHP premium, even though they told you that you could not have two policies through the same insurer in the same month. It is fully within CDPHP's authority to refund you the CHP premium for July 2016. You can contact CDPHP to pursue an appeal of this matter through them. You can also contact the NY State Department of Financial Services at (800) 342-3736 if you wish to get information regarding filing a complaint about your insurer.

Decision

The August 9, 2016 plan disenrollment notice is AFFIRMED.

Effective Date of this Decision: May 2, 2017

How this Decision Affects Your Eligibility

Your child was enrolled in a full price CHP plan from January 1, 2016 to August 31, 2016.

You can contact the NY State Department of Financial Services at (800) 342-3736 if you wish to receive information regarding filing a complaint about your insurer.

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 August 9, 2016 plan disenrollment notice is AFFIRMED.

Your child was enrolled in a full price CHP plan from January 1, 2016 to August 31, 2016.

You can contact the NY State Department of Financial Services at (800) 342-3736 if you wish to receive information regarding filing a complaint about your insurer.

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।

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&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.

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).