



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

Notice of Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000018717

[REDACTED]

Dear [REDACTED],

On August 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 4, 2017 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).

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

Decision

Decision Date: August 24, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000018717



Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health properly cancel your child's Child Health Plus plan effective May 31, 2017?

Procedural History

On December 9, 2016, NY State of Health (NYSOH) received your application for financial assistance with health insurance.

On December 10, 2016, NYSOH issued an eligibility determination stating that your child was eligible for a full price Child Health Plus plan, effective January 1, 2017.

Also on December 10, 2016, NYSOH issued a plan enrollment notice confirming your child's enrollment in her full price Child Health Plus plan, effective January 1, 2017.

On May 3, 2017, NYSOH received your application for financial assistance with health insurance.

On May 4, 2017, NYSOH issued a plan disenrollment notice confirming that your child's enrollment in her full price Child Health Plus plan ended effective May 31, 2017.

Also on May 4, 2017, NYSOH issued a discontinuance notice stating that your child was no longer eligible to receive health insurance through NYSOH, effective June 1, 2017 because you no longer wanted to receive coverage through NYSOH.

On May 4, 2017, you spoke to the NYSOH's Account Review Unit and requested an appeal of the May 4, 2017 plan disenrollment notice insofar as your child's Child Health Plus plan ended May 31, 2017 and not March 31, 2017.

On August 15, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and 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's end date of her Child Health Plus plan.
- 2) You testified that your spouse obtained employer sponsored health insurance for your family, including your child, as of April 1, 2017.
- 3) You testified that you contacted your child's Child Health Plus plan on April 3, 2017 to cancel your child's plan.
- 4) You testified that your child's Child Health Plus plan informed you that you had already paid for April 2017, so your child would be enrolled into coverage until the end of April 2017.
- 5) You testified that your child's Child Health Plus plan premium was automatically deducted from your bank account on or around April 15, 2017, and you received a bill on or around April 15, 2017 for the premium payment for June 2017.
- 6) You testified that after realizing that you had been charged another premium payment by your child's Child Health Plus plan that you called the Child Health Plus plan, and asked them why you were still being charged.
- 7) You testified that your child's Child Health Plus plan informed you that you would have to contact NYSOH in order to cancel your child's coverage.
- 8) The record indicates, and you testified, that the first time you contacted NYSOH to disenroll your child from coverage was on May 3, 2017.

- 9) You testified that you would like your child to be disenrolled from her Child Health Plus plan as of March 31, 2017 because your child had coverage through another plan during that time.

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

Applicable Law and Regulations

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)).

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 cancelled your child's Child Health Plus plan effective May 31, 2017.

You testified that you contacted your child's Child Health Plus plan on April 3, 2017 in order to request that your child be disenrolled from her Child Health Plus plan. You further testified that you were told that you had paid for April 2017 already, and that her coverage would continue until the end of April 2017. However, you testified that on or around April 15, 2017 you noticed that you had been charged for another month's premium from your child's Child Health Plus plan. You testified that you called your child's Child Health Plus plan after realizing you had been charged for another month's premium, and they informed you that you would have to call NYSOH in order to cancel your child's coverage.

You testified, and the record reflects, you contacted the NYSOH on May 3, 2017 to cancel your child's Child Health Plus plan due to the fact that she had other insurance through your spouse's employer sponsored health insurance plan.

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.

Since you contacted NYSOH to disenroll your child from coverage on May 3, 2017, it was proper for NYSOH to disenroll your child as of the first day of the month following your request, that is June 1, 2017.

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).

Therefore, the May 4, 2017 disenrollment notice confirming your child's disenrollment from her Child Health Plus plan, effective May 31, 2017, is correct and must be AFFIRMED.

Decision

The May 4, 2017 disenrollment notice is AFFIRMED.

Effective Date of this Decision: August 24, 2017.

How this Decision Affects Your Eligibility

Your child's enrollment in her Child Health Plus plan ended effective May 31, 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

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).

- 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 May 4, 2017 disenrollment notice is AFFIRMED.

Your child's enrollment in her Child Health Plus plan ended effective May 31, 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)

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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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 nkyerekeremu a, ye sre wo, fre 1-855-355-5777. ye&tumi 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.

אײַדיש (Yiddish)

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).

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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