

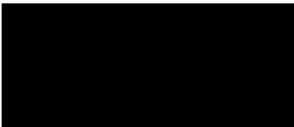


STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029181



Dear [REDACTED]

On April 27, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 22, 2018 plan disenrollment notice and discontinuance 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029181



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 eligibility for and enrollment in her Child Health Plus plan ended effective February 28, 2018?

Procedural History

On September 5, 2017, NY State of Health (NYSOH) received your child's application for financial assistance and health insurance.

On September 6, 2017, NYSOH issued an eligibility determination notice stating your child was eligible for Child Health Plus for a cost of \$60.00 per month for a limited time, effective August 1, 2017. The notice stated your information was sent to your local Department of Social Services to determine eligibility for Medicaid on a different basis. The notice also directed you to provide proof of your child's citizenship status and Social Security Number by December 4, 2017.

On October 9, 2017, NYSOH issued a plan enrollment notice confirming your child's enrollment in a Child Health Plus plan at a cost of \$60.00 per month, effective September 1, 2017.

On February 21, 2018, NYSOH redetermined your child's eligibility after you asked that her coverage end.

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Also on February 21, 2018, you contacted NYSOH's Account Review Unit and appealed the date your child was disenrolled from her Child Health Plus plan, requesting her disenrollment be made effective September 1, 2017.

On February 22, 2018, NYSOH issued a discontinuance notice stating your child was no longer eligible for Medicaid, Child Health Plus, the Essential Plan, advance payments of the premium tax credit, cost sharing reductions, or to purchase a qualified health plan at full cost, effective April 1, 2018. The notice stated this was because you no longer wanted your child to receive coverage.

On February 22, 2018, NYSOH issued a disenrollment notice stating your child's enrollment in a Child Health plus plan was ending February 28, 2018. The notice stated this was because you asked NYSOH to end her coverage on February 21, 2018.

On April 27, 2018, you had a telephone hearing with a Hearing Officer from the NYSOH's Appeals Unit. The record was developed during the hearing and held open up to 15 days for you to provide supporting documentation.

On April 28, 2018, two documents were viewable in your NYSOH account and have been incorporated into the record as Appellant's Exhibit 1 (see Documents [REDACTED] [REDACTED]). The record was closed that day.

Findings of Fact

A review of the record supports the following findings of fact:

- 1) You testified, and your NYSOH account indicates, that your newborn child was found eligible for Child Health Plus at a cost of \$60.00 per month effective September 1, 2017.
- 2) Your child was born on [REDACTED] [REDACTED] [REDACTED]
- 3) You testified that you contacted NYSOH on February 21, 2018, to disenroll your child from her Child Health Plus coverage.
- 4) You testified your child was determined eligible for Medicaid effective September 1, 2017, by your local Human Resources Administration (HRA) office.
- 5) You testified you were not aware that you needed to contact NYSOH to let them know your child was determined no longer eligible for Child Health Plus because you received a letter from your child's health plan in November 2017, stating her coverage was going to end December 1, 2017 as she was now eligible for Medicaid.

- 6) You provided a copy of the letter you received from your child's Child Health Plus plan, dated November 20, 2017, stating your child was eligible for Medicaid and your child would therefore be disenrolled from her Child Health Plus plan as of December 1, 2017 (see Document [REDACTED])
- 7) You provided a copy of a letter from your local HRA office, dated November 15, 2017, stating your child's application for Medicaid, dated September 26, 2017, was accepted and she was eligible for all Medicaid covered care and services effective September 1, 2017 (see Document [REDACTED])
- 8) Your NYSOH account shows your child's enrollment in Child Health Plus ended as of November 30, 2017.
- 9) You testified that you are seeking to have your child's Child Health Plus plan end as of September 1, 2017.
- 10) You testified that you processed all claims for your child through her Medicaid coverage.
- 11) According to your NYSOH account, your child resides with you in [REDACTED], NY.

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 Child Health Plus 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

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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)).

If the enrollee gains access to a state health benefits plan or becomes enrolled in other health insurance, the enrollee shall be disenrolled effective the first day of the month following the date that the enrollee provides information regarding other insurance (NYSDOH 2008-2012 Model Contract (Appendix C Section 12.3)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your child's eligibility and enrollment in her Child Health Plus plan ended effective February 28, 2018.

Your child was determined eligible for and enrolled in a Child Health Plus plan, effective September 1, 2017.

NYSOH received an updated application that your child was no longer applying for insurance on February 21, 2018. On February 22, 2018, NYSOH issued a discontinuance notice stating your child was no longer eligible for Child Health Plus and a plan disenrollment notice stating that your child's Child Health Plus plan coverage would end as of February 28, 2018.

Generally, enrollees may request disenrollment from their Child Health Plus 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.

You testified and the record supports that, on February 21, 2018, you first contacted NYSOH and requested that your child's enrollment be ended in her Child Health Plus plan and that she was no longer seeking insurance through NYSOH.

Since you contacted NYSOH on February 21, 2018, to request that your child be disenrolled from her Child Health Plus plan, her eligibility for and enrollment in that plan coverage would ordinarily have ended the first day of the month following the February 21, 2018 request, which would be March 1, 2018.

However, you testified and the record supports that your child became eligible for and enrolled in Medicaid as of September 1, 2017, as her application was approved by your local HRA office, which is supported by the November 15, 2017 letter from that office (see Document [REDACTED])

Further, you testified you were not aware that you needed to contact NYSOH to let them know your child was determined no longer eligible for Child Health Plus because you received a letter from your child's health plan in November 2017 stating her coverage was going to end December 1, 2017 as she was now eligible for Medicaid. You provided a copy of the letter you received from your child's Child Health Plus plan, dated November 20, 2017, stating your child was eligible for Medicaid and she would therefore be disenrolled from her Child Health Plus plan as of December 1, 2017 (see Document [REDACTED]). Your NYSOH account now shows your child's disenrollment date as being November 30, 2017.

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 child becomes eligible for Medicaid. Since the record now shows your child was eligible for Medicaid as of September 1, 2017, she was not eligible to remain enrolled in Child Health Plus as of that date.

Therefore, the February 22, 2018 discontinuance and plan disenrollment notices are MODIFIED to reflect respectively that your child's eligibility for Child Health Plus and plan enrollment in a Child Health Plus plan ended September 1, 2017.

Your case is RETURNED to NYSOH to ensure your child's disenrollment from her Child Health Plus plan is effective as of September 1, 2017, and to notify you accordingly.

Decision

The February 22, 2018 discontinuance notice and plan disenrollment notice are MODIFIED to reflect respectively that your child's eligibility for Child Health Plus and plan enrollment in a Child Health Plus plan ended September 1, 2017.

Your case is RETURNED to NYSOH to ensure your child's disenrollment from her Child Health Plus plan is effect as of September 1, 2017, and to notify you accordingly.

Effective Date of this Decision: May 24, 2018

How this Decision Affects Your Eligibility

Your child's eligibility for and enrollment in her Child Health Plus plan should have ended September 1, 2017.

Your case is being sent back to NYSOH to effectuate this change. NYSOH will notify you once it is done.

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 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).

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 February 22, 2018 discontinuance notice and plan disenrollment notice are MODIFIED to reflect respectively that your child's eligibility for Child Health Plus and plan enrollment in a Child Health Plus plan ended September 1, 2017.

Your case is RETURNED to NYSOH to ensure your child's disenrollment from her Child Health Plus plan is effect as of September 1, 2017, and to notify you accordingly.

Your child's eligibility for and enrollment in her Child Health Plus plan should have ended September 1, 2017.

Your case is being sent back to NYSOH to effectuate this change. NYSOH will notify you once it is done.

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 مجانًا.

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 मदद 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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