Child Health Plus Overview

Child Health Plus

Child Health Plus (CHP) is a health care program for uninsured children under the age of 19. It was previously referred to as CHP A (children's Medicaid) and B (the State's Child Health Insurance Program). CHP offers health care to children who are above the Medicaid income levels or who are ineligible for Medicaid because of their immigration status. There is no resource test. Enrollees in CHP must enroll in a managed care plan. See N.Y. Pub. Health L. Â§ 2511. In general CHP enrollees cannot be eligible for Medicaid. However, if they are only eligible for Medicaid with a spenddown, they can enroll in CHP.
All children in Medicaid and CHP receive **one year of guaranteed coverage**, even if their income goes above the guidelines. 42 U.S.C. Â§1396a(e)(12). Enrollees do have a duty to report changes that affect their eligibility. N.Y. Pub. Health L. Â§ 2511(4).
There is **no per service cost sharing** (i.e. no co-pays or co-insurance) in the CHP program**.** Although enrollees will not have to pay co-pays or exhaust deductibles, they may have to pay a monthly premium depending on their income level to receive CHP coverage. See CHP Eligibility and Cost for a listing of CHP income limits and monthly premiums.

Who Is Eligible for CHP?

Â· **Age**. All enrollees must be under the age of 19.

Â· **Income**. In general, all children who are not eligible for Medicaid are eligible for CHP. Families with incomes below 160% of the Federal Poverty Level (FPL) can receive free insurance for their children; families with incomes over that pay on a sliding scale from about $9-$60/month per child. If the family income is above 400% of the Federal Poverty Level, they will have to pay full price for the monthly premiums - this amount is now charged by the health plan. See CHP Eligibility and Cost for more information.

Â· **No resource/assets test**.

Â· **Citizenship/Immigration Status**. CHP is available to children regardless of immigration status. The only children who may not be eligible are those on visitors' visas or other short-term visas because they may not be able to show they are New York state residents.

Â· **Residency**. All CHP enrollees must be New York State residents.

Â· **Other Health Insurance Coverage**. Children cannot be covered under other health insurance and receive CHP. They also cannot be eligible for coverage under the public employees state health benefits plan.

What Does CHP cover?

All applicants/recipients must enroll in a CHP managed care plan and all services, including pharmacy and family planning, are provided through the plan. Enrollees receive primary, preventive, specialty and inpatient care. Unlike Medicaid, CHP will not cover orthodontia treatment, long-term care services for the chronically ill, like nursing home stays, personal care services, hospice care, intermediate care facilities for the developmentally disabled and private duty nursing. CHP also does not cover non-emergency transportation, medical supplies and over-the-counter drugs not prescribed by a doctor.

How to Apply for CHP

Applicants can now access CHP through the New York State of Health through the Health Insurance Marketplace website, by meeting with an in-person assistor in their area, or by phone (1.855.355.5777).

Applicants for CHP are required to provide documentation of the child's age, that they live in New York State and proof of their monthly income.

Presumptive Eligibility. When an application is submitted directly with a health plan, a child is presumptively eligible for benefits for up to 60 days while her application is being processed. Once approved for CHP, eligibility lasts for 12 months.

Recertification Process. CHP beneficiaries must recertify annually. Recertification can be done through the New York State of Health Marketplace.

Appeals in CHP

Children enrolled in CHP have the same rights as commercial managed care consumers. The procedures are found in both the Public Health Law and Insurance Law, for ease of use specific provisions are only cited to the Public Health Law below. They do not have Fair Hearing rights.

Grievance Procedures

All managed care plans must let enrollees file grievances when they have a problem with their plan or the care they are receiving. See N.Y. Pub. Health L. Â§4408-a; see also, Ins. L. Â§ 4802. These procedures follow strict time lines and enrollees have a right to expedited decisions if a delay would significantly increase risk to health. N.Y. Pub. Health L. Â§4408-a(4). If an enrollee receives an adverse determination on her grievance, she is entitled to appeal this decision. N.Y. Pub. Health L. Â§4408-a(8)-(1). Plans cannot retaliate against enrollees for filing a grievance. N.Y. Pub. Health L. Â§4408-a(13).

Utilization Review (UR) and UR Appeals

UR is an inquiry by the health plan that looks at whether health services that were provided, are being provided or will be provided in the future are medically necessary. See N.Y. Pub. Health L. Â§ 4900, et.seq.; see also, Ins. L. Â§ 4900, et. seq. For ease of use, I have only cited to the Public Health Law here. UR determinations are made by health care professionals, but only clinical peer reviewers can make adverse determinations. A clinical peer reviewer is someone who is "in the same profession and same or similar specialty as the health care provider who typically managesthe medical condition or disease or provides the health care service or treatment under review." PHL Â§ 4900(2) As with grievances, there are specific timelines for issuing determinations, and expedited decisions can be requested. If a UR decision is not issued within the prescribed time, it is considered adverse. N.Y. Pub. Health L. Â§Â§ 4903-4904

If an enrollee receives an adverse UR determination, she is entitled to a UR appeal. As with a grievance appeal, these appeals are handled internally by the health plan. However, since UR appeals are challenges to the plan's determination that the requested care is not medically necessary, they must be reviewed by a clinical peer reviewer who was not involved in the UR decision. Strict timelines govern UR appeals. If a delay in a decision poses a significant health risk to the enrollee, they are entitled to an expedited UR appeal decision.

External Appeals of Adverse UR Appeal Determinations

Enrollees who receive adverse determinations on internal plan appeals based on lack of medical necessity or experimental or investigation treatment are entitled to appeal

externally. N.Y. Pub. Health L. Â§4910. Applications for external appeals must be submitted within 45 days of the adverse determination by the health plan. N.Y. Pub. Health L. Â§4914(2)(a). They are submitted directly to the Insurance Department. Once the application is complete, the Insurance Department randomly assigns it to one of three independent review agencies. Decisions must be issued within 30 days unless the appeal has been expedited, in which case a decision must be issued within three days. N.Y. Pub. Health L. Â§4914(2)(b),(c). Decisions by the review agents are binding on the plan and the enrollee. N.Y. Pub. Health L. Â§4914(2)(d)(iv). External review agents are not liable for damages based on their decision unless the opinion was rendered in bad faith or involved gross negligence. N.Y. Pub. Health L. Â§4914(3)

This article was authored by the Health Law Unit of the Legal Aid Society.

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