



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

**Notice of Decision**

Decision Date: April 21, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013061

[REDACTED]

Dear [REDACTED],

On February 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health’s April 16, 2016 eligibility determination and enrollment confirmation notices and the June 7, 2016 eligibility determination and enrollment confirmation 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 21, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013061

[REDACTED]

## Issue

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

Was your appeal of the NY State of Health's (NYSOH) April 16, 2016 and June 7, 2016 eligibility determination and enrollment confirmation notices timely?

## Procedural History

On April 16, 2016, NYSOH issued an eligibility determination notice stating your child was eligible to enroll in Child Health Plus, effective May 1, 2016.

Also on April 16, 2016, NYSOH issued an enrollment confirmation notice, based on your April 15, 2016 plan selection, stating your child was enrolled in a Child Health Plus plan with coverage effective May 1, 2016.

Additionally, on April 16, 2016, NYSOH issued a notice stating your request for help paying for your child's medical bills from March 1, 2016 to March 31, 2016 was denied because your child was not eligible for Medicaid during this period due to being over the allowable household income limit.

On June 7, 2016, NYSOH issued an eligibility determination notice, based on your June 6, 2016 updated application, stating your child was eligible to enroll in Child Health Plus, effective July 1, 2016.

Also on June 7, 2016, NYSOH issued an enrollment notice confirming your child was enrolled in a Child Health Plus plan with coverage effective May 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).

Additionally, on June 7, 2016, NYSOH issued a notice stating your request for help paying for your child's medical bills from April 1, 2016 to April 30, 2016 was denied because the program your child was eligible for could not pay for any care received in the past.

On November 3, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the April 16, 2016 and June 7, 2016 eligibility determination and enrollment confirmation notices insofar as your child's Child Health Plus plan coverage was not effective as of April 1, 2016.

On February 16, 2017, you had a telephone hearing with a Hearing Officer from 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 are appealing only your newborn child's coverage start date.
- 2) Your child was born on [REDACTED].
- 3) You testified your child was covered under your health insurance plan for one month until April 24, 2016.
- 4) NYSOH received your child's initial application for health insurance on April 6, 2016.
- 5) NYSOH issued a notice on April 7, 2016 indicating it was referring your child's case to your local department of social services due to information provided regarding your child's health needs. You testified an employee from the Medicaid office at the hospital submitted the initial application for you and you are unsure what information was included in that application.
- 6) NYSOH received an updated application for health insurance for your child on April 15, 2016 and determined your child was eligible to enroll in Child Health Plus, effective May 1, 2016.
- 7) You enrolled your child into a Child Health Plus plan on April 15, 2016 with a coverage start date of May 1, 2016.
- 8) You testified you are seeking to have your child's Child Health Plus coverage backdated to April 1, 2016 because she has outstanding medical bills from April.

- 9) Your account confirms you contacted NYSOH again on June 6, 2016 regarding your child's eligibility for coverage in April 2016.
- 10) NYSOH again denied your request for retroactive health coverage for your child for the month of April 2016 and confirmed your child's May 1, 2016 Child Health Plus coverage start date.
- 11) Your account confirms you accessed your NYSOH account on November 3, 2016 and submitted an updated application for health insurance for your child.
- 12) NYSOH again confirmed your child's May 1, 2016 Child Health Plus coverage start date.
- 13) You appealed your child's Child Health Plus coverage start date.

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

## **Applicable Law and Regulations**

### Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination; and (5) a denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

## **Legal Analysis**

The only issue under review is whether your appeal of NYSOH's April 16, 2016 and June 7, 2016 eligibility determination and enrollment confirmation notices was timely.

NYSOH issued an eligibility determination notice dated April 16, 2016, stating your child was eligible to enroll in a Child Health Plus plan, effective May 1, 2016. On the same day, NYSOH issued an enrollment notice confirming your child's May 1, 2016 enrollment in her Child Health Plus plan. You are appealing the May 1, 2016 coverage start date of your child's Child Health Plus plan as indicated by the April 16, 2016 eligibility determination and enrollment confirmation notices.

Pursuant to the above cited regulations, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH. The appeal in this case was not filed until November 3, 2016, long after the 60-period in which to appeal the April 16, 2016 eligibility determination.

However, your account confirms you contacted NYSOH on June 6, 2016 to request a new determination regarding your child's eligibility for health coverage for the month of April 2016. While a formal appeal was not filed at that time, it is sufficient evidence that you were contesting the April 16, 2016 determinations concerning your child's May 1, 2016 Child Health Plus coverage start date.

Following your June 6, 2016 telephone call, NYSOH issued an updated enrollment notice on June 7, 2016 confirming your child's May 1, 2016 Child Health Plus coverage start date. NYSOH also issued a notice on June 7, 2016 denying your request for retroactive coverage for your child for the month of April 2016. These notices confirmed the April 16, 2016 eligibility determination and enrollment confirmation notices indicating your child's coverage through her Child Health Plus plan was effective May 1, 2016. There is no evidence in your account that you contacted NYSOH to contest the June 7, 2016 determinations prior to filing the appeal on November 3, 2016.

For an appeal to have been valid on the issue of your child's Child Health Plus coverage start date as confirmed in the June 7, 2016 enrollment confirmation notice, an appeal would have to have been filed by August 6, 2016. As discussed above, the appeal in this matter was not filed until November 3, 2016. Furthermore, there is no evidence you contacted NYSOH to dispute your child's coverage start date at any time between your June 6, 2016 telephone call and five months later when you finally filed the appeal.

Therefore, there has been no timely appeal of the April 16, 2016 eligibility determination and enrollment confirmation notices or the June 7, 2016 eligibility determination and enrollment confirmation notices, and your appeal on the issue of your child's May 1, 2015 Child Health Plus coverage start date is **DISMISSED**.

It is noted that children eligible for Child Health born prior to January 1, 2017 are not eligible to enroll in coverage effective as of the date of their birth.

## **Decision**

The April 16, 2016 eligibility determination and enrollment confirmation notices and the June 7, 2016 eligibility determination and enrollment confirmation notices are DISMISSED as untimely.

**Effective Date of this Decision:** April 21, 2017

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

This decision does not change your child's eligibly.

Your child's Child Health Plus plan coverage was effective May 1, 2016.

## **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 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 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 April 16, 2016 eligibility determination and enrollment confirmation notices and the June 7, 2016 eligibility determination and enrollment confirmation notices are DISMISSED as untimely.

This decision does not change your child's eligibility.

Your child's Child Health Plus plan coverage was effective May 1, 2016.

### **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 okyerε 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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