



STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
PO Box 11729  
Albany, NY 12211

### Notice of Decision

Decision Date: April 12, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000026723

[REDACTED]

[REDACTED]

On March 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's June 6, 2017 eligibility determination 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  
PO 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 NY State of Health 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(b).

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 12, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000026723

[REDACTED]

## Issue

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

Was your appeal of the June 6, 2017 eligibility determination notice, timely?

## Procedural History

On June 6, 2017, NYSOH issued an eligibility determination notice, based on your June 5, 2017 updated application, stating your spouse was eligible for the Essential Plan with no monthly premium, effective July 1, 2017. The notice indicated your spouse was eligible for the Essential Plan, because she was in the first five years of her qualified immigration status or was living in the United States under the color of law (PRUCOL).

Also on June 6, 2017, NYSOH issued an enrollment notice confirming your spouse's enrollment in an Essential Plan, effective June 1, 2017.

On January 3, 2018, you updated your application adding your newborn child to your account. That day a preliminary eligibility determination was prepared finding your spouse eligible for the Essential Plan and your newborn child conditionally eligible for Medicaid, effective January 1, 2018.

Also on January 3, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar as your spouse was not eligible for Medicaid, effective July 1, 2018.

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On January 4, 2018, NYSOH issued an eligibility determination notice, based on the January 3, 2018 updated application, stating your spouse was eligible for the Essential Plan with no monthly premium, effective February 1, 2018. The notice indicated your spouse was eligible for the Essential Plan, because she was in the first five years of her qualified immigration status or was PRUCOL. The notice also stated your child was conditionally eligible for Medicaid, effective January 1, 2018. You were directed to submit proof of your child's citizenship status and Social Security card by April 3, 2018 to confirm his eligibility.

Also on January 4, 2018, NYSOH issued an enrollment notice confirming your spouse was enrolled in an Essential Plan since June 1, 2017. The notice also confirmed your child's enrollment, based on your January 3, 2018 plan selection, in a Medicaid Managed Care plan, effective February 1, 2018.

On March 12, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed thereafter.

## **Findings of Fact**

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

- 1) According to your account, your spouse was initially found conditionally eligible for Medicaid, effective April 1, 2017, pending documentation verifying her immigration status.
- 2) On April 28, 2017, you uploaded a copy of your spouse's permanent resident card issued January 30, 2017.
- 3) NYSOH verified your spouse's immigration documentation and determined her eligible for the Essential Plan, effective June 1, 2017, based on the documentation submitted showing she has had her current immigration status for less than five years.
- 4) Your spouse enrolled in an Essential Plan, effective June 1, 2017.
- 5) On June 5, 2017, your application was updated and your spouse was again determined eligible for the Essential Plan, effective July 1, 2017.
- 6) You testified that on June 5, 2017, you contacted NYSOH to update your application to report your spouse's pregnancy.
- 7) According to your account, the application submitted on behalf of you and your spouse on June 5, 2017 indicated your spouse was not pregnant.

- 8) You testified, and your account indicates, your child was born on [REDACTED]
- 9) Your account confirms that your spouse was enrolled in an Essential Plan in December 2017.
- 10) Your account was updated on January 3, 2018 to add your newborn and he was determined conditionally eligible for Medicaid, effective January 1, 2018, pending confirmation of his citizenship status and Social Security number.
- 11) A Medicaid Managed Care plan was selected on behalf of your child on January 3, 2018 and coverage through that plan became effective on February 1, 2018.
- 12) According to your account, your child was determined eligible for retroactive Medicaid assistance for the month of December 2017.
- 13) You appealed insofar as your spouse was not eligible for and enrolled in Medicaid at the time of your child's birth.
- 14) You testified that there are outstanding medical bills from the hospital relating to the birth of your child. You are unsure whether these bills are for your spouse or your child. You testified that you have submitted your spouse's insurance information to the hospital and you do not know whether it has been resolved.
- 15) You testified that your spouse's health plan told you that your spouse should have been eligible for and enrolled in Medicaid at the time of your child's birth due to her pregnancy and that your child should have been covered under the same plan.
- 16) You testified that you did not appeal your spouse's eligibility until January 2018, because you were not aware she should have had a different eligibility until you spoke to her health plan in January 2018.

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

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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) a failure by NYSOH to provide timely notice of an eligibility determination 45 CFR § 155.505; and (4) a denial of a request for a special enrollment period (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 sixty (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 sole issue under review is whether your appeal of the June 6, 2017 eligibility determination notice was timely.

On June 5, 2017, NYSOH received an updated application submitted on behalf of you and your spouse. Although you testified that you contacted NYSOH on June 5, 2017 to report your spouse's pregnancy, your account confirms that the application submitted that day did not indicate your spouse was pregnant. Thus, the resulting eligibility determination finding your spouse eligible for the Essential Plan, effective July 1, 2017, was based on information in the application indicating your spouse was not pregnant.

The evidence establishes that your newborn child was born on [REDACTED], that your spouse was enrolled in an Essential Plan at the time of the birth, and that there were no applications or eligibility determinations issued by NYSOH between June 6, 2017 and the January 3, 2018 application adding your newborn child to the account. You testified that you are appealing insofar as your spouse was not eligible for and enrolled in Medicaid at the time of your child's birth, because you had been advised by her health plan that her pregnancy should have resulted in a change of eligibility.

Since, as discussed above, there were no additional eligibility determinations issued between June 6, 2017 and January 4, 2018, the determination providing your spouse's eligibility for December 2017 was the June 6, 2017 eligibility determination stating she was eligible for the Essential Plan, effective July 1, 2017. Therefore, that is the determination at issue.

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.

For an appeal to have been valid on the issue of your spouse's eligibility for the month of December 2017, as stated in the June 6, 2017 eligibility determination

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notice, an appeal should have been filed by August 5, 2017. The record reflects that the appeal in this matter was not filed until January 3, 2018, long after the 60-day timeframe in which to appeal the June 6, 2017 eligibility determination. There is no evidence in the record to justify tolling the regulatory deadline in which to appeal that determination.

Since there has been no timely appeal of the June 6, 2017 eligibility determination notice, your appeal of your spouse's eligibility for the month of December 2017 must be DISMISSED.

## **Decision**

Your appeal of the June 6, 2017 eligibility determination notice is DISMISSED.

**Effective Date of this Decision:** April 12, 2018

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

The Appeals Unit will not review your spouse's eligibility for the month of December 2017, because there was no timely appeal of that issue.

## **If You Disagree with this Decision (Appeal Rights)**

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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.

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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  
PO Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

### **Summary**

Your appeal of the June 6, 2017 eligibility determination notice is **DISMISSED**.

The Appeals Unit will not review your spouse's eligibility for the month of December 2017, because there was no timely appeal of that issue.

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## **Legal Authority**

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**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، يرجى 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 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 srε wo, frε 1-855-355-5777. ye&εtumi 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.