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

Notice of Decision

Decision Date: April 06, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028202

[redacted]

[redacted]

On March 29, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 22, 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
  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 06, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028202

[redacted]

Issue

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

> Does the Appeals Unit of NY State of Health (NYSOH) have the authority to direct any changes to the wording in notices issued by NYSOH?

Procedural History

On December 7, 2017, you filed an application for financial assistance with health insurance on behalf of yourself and your child.

On December 8, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $132.00 per month in APTC, and your child was eligible to enroll in Child Health Plus (CHP), effective January 1, 2018.

Also on December 8, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a gold level QHP with the application of your APTC to your monthly premium, beginning January 1, 2018. The notice also confirmed that your child was enrolled in a CHP plan with no monthly premium, beginning January 1, 2018.

On December 21, 2017, NYSOH redetermined your household's eligibility.

On December 22, 2017, NYSOH issued a notice of eligibility determination stating that you and your child were eligible to receive up to $489.00 per month in APTC, effective February 1, 2018. The notice further stated that your child was no longer eligible for CHP because he would turn 19 on "[redacted]" [*sic*],

and CHP is only available to children eighteen years old and younger. The notice advised you that you would need to select a health plan for your child.

Also on December 22, 2017, NYSOH issued a disenrollment notice, stating that your child's enrollment in his CHP plan was ending, effective January 31, 2018, because his plan was only available to individuals who are eighteen years of age or younger.

That same day, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in your gold level QHP as of January 1, 2018, and advising you to pick a health plan for your child.

On January 29, 2018, you updated your NYSOH account.

On January 30, 2018, NYSOH issued a notice of eligibility redetermination stating that you and your child were eligible to receive up to $489.00 per month in APTC, effective March 1, 2018.

Also on January 30, 2018, NYSOH issued a letter confirming you and your child's enrollment in your gold level QHP, with your new APTC amount applied as of March 1, 2018.

That same day, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination and enrollment confirmation notices. insofar as they began your child's financial assistance eligibility and enrollment in a QHP on March 1, 2018 and not February 1, 2018.

On March 29, 2018, 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 support the following findings of fact:

1) You submitted an application to NYSOH for financial assistance on December 7, 2017.

2) You testified, and your NYSOH account reflects, that your child reached the age [redacted] on [redacted].

3) You testified that you received the December 22, 2017 notices stating that your child's CHP enrollment and coverage were ending as of January 31, 2018.

4) You testified that the notices you received did not advised you that you needed to select a health plan for your child by January 15, 2018 if you wanted his coverage to begin as of February 1, 2018.

5) You testified that you do not have any outstanding medical bills for your son for the month of February 2018, and that you are no longer appealing to have his coverage backdated to February 1, 2018.

6) You testified that you are appealing because you want to make sure that this will not happen to anyone else, and as a matter of principle.

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

Applicable Law and Regulations

Appealable Issues

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) a failure by NYSOH to provide timely notice of an eligibility determination; 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)).

Legal Analysis

The issue under review is whether the Appeals Unit of NYSOH has the authority to direct any changes to the wording in notices issued by NYSOH.

NYSOH issued a notice on December 22, 2017 stating that your child was newly eligible to share up to $489.00 per month in APTC with you, and no longer eligible for CHP, effective February 1, 2018. The notice further stated that you needed to select a health plan on behalf of your child prior to the ending of his CHP coverage, or he could be without coverage. You testified that the notice did not tell you that you needed to select a plan by January 15, 2018 for coverage to start on February 1, 2018, only that you needed to pick a plan before your child's coverage ended (on January 31, 2018), which you did (on January 29, 2018).

However, you also testified that, as of the hearing, you were no longer looking for your child's coverage to be backdated, and that you were only appealing as a matter of principle, and to make sure this does not happen to anyone else.

NYSOH Appeals Unit only has the authority to review issues related to the following: (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) a failure to provide timely notice of an eligibility determination, and (4) a denial of a special enrollment period.

It is noted that you are correct in your assertion that the December 22, 2017 eligibility determination notice failed to inform you that you needed to select a health plan on or before January 15, 2018, for the new enrollment to take effect on February 1, 2018. However, you testified at the hearing that you were no longer looking for your child's coverage to be backdated, and were instead appealing so that NYSOH would change their notices, and so this would not happen to anyone else.

Since the Appeals Unit's authority extends only to the outcomes caused by NYSOH's notices, not the wording or contents of the notices themselves, and has no authority to direct changes to be made in any given notice, your appeal of the wording of NYSOH's December 22, 2017 eligibility determination is DISMISSED as an invalid appeal.

Decision

Your appeal of the wording and contents of the December 22, 2017 eligibility determination notice is DISMISSED as an invalid appeal.

Effective Date of this Decision: April 06, 2018

How this Decision Affects Your Eligibility

This decision does not change your child's eligibility.

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 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

Your appeal of the wording and contents of the December 22, 2017 eligibility determination notice is DISMISSED as an invalid appeal.

This decision does not change your child's eligibility.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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).

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。我们可以为您免费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।

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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई नि:शुल्क 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 yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 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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