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

NOTICE OF DISMISSAL – INVALID APPEAL REQUEST

Notice Date: December 14, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000022409

[redacted]

Dear [redacted],

On December 20, 2016, NYSOH issued an eligibility determination notice stating that you and your adult child (child) were eligible to share in up to $440.00 per month in advance payments of the premium tax credit (APTC), effective February 1, 2017. That same day, NYSOH issued a plan enrollment notice confirming your and your child's enrollment in a bronze-level qualified health plan with a monthly premium of $169.81 after your shared monthly APTC of $440.00 was applied, effective February 1, 2017.

On August 24, 2017, you updated your account and removed your child from that account because she was to begin to receive employer-sponsored health insurance as of August 1, 2017.

On August 25, 2017, NYSOH redetermined your eligibility based on this new information and found you eligible for $3.00 per month in advance payment of the premium tax credit, effective October 1, 2017, and issued a notice to this effect. That same day, a plan enrollment notice was issued confirming your enrollment in a bronze-level qualified health plan with a premium of $355.71 per month after your monthly APTC of $3.00 was applied as of February 1, 2017.

Also on August 25, 2017, NYSOH issued a disenrollment notice stating that your child's coverage ended March 31, 2017, because she was no longer eligible to enroll in health insurance through NYSOH.

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).).

On September 3, 2017, NYSOH redetermined your eligibility, based on your September 2, 2017 updated application, and found you eligible for $74.00 per month in APTC, effective October 1, 2017, and issued a notice to this effect. That same day, a plan enrollment notice was issued confirming your enrollment in a bronze-level qualified health plan with a premium of $284.71 per month after your monthly APTC of $74.00 was applied as of February 1, 2017.

On September 14, 2017, you filed an appeal insofar as your qualified health plan had retroactively billed you as of February 1, 2017, for the new monthly premium of $284.71 per month.

At your hearing held on November 30, 2017, you testified that you believe, upon your qualified health plan receiving NYSOH's September 3, 2017 plan enrollment notice, the plan retroactively billed you from February 2017 or March 2017 for the full monthly premium. As a result, you received a bill dated September 3, 2017 for $1,471.00. The Hearing Officer held the record open to December 15, 2017, to allow you time to submit supporting documentation to show that the increased premium billing had been made effective retroactively.

On December 7, 2017, you submitted six health plan billing statements dated June 3, 2017 through November 3, 2017. These documents were made part of the record as "Appellant's Exhibit A." The record closed that day.

The billing statement, dated August 3, 2017, shows you were billed by your health plan a total of $169.81 for your bronze-level coverage, which was your premium responsibility for you and your child as of February 1, 2017. According to the September 3, 2017 billing invoice, you were billed by your health plan a total of $1,471.11 for coverage in your bronze-level qualified health plan for unknown months. Your child was not included on that billing statement (*see* Appellant's Exhibit A). You believe you were overbilled for coverage for just yourself by the health plan from March 1, 2017 through July 31, 2017, when your child should have been have included and your premium responsibility should have remained at $169.81 per month.

You testified at the hearing on November 30, 2017 that you would like your bill corrected because you cannot pay the increased premium amount.

Why Your Appeal Request Is Not Valid

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 the Exchange to provide timely notice of an eligibility determination 45 CFR § 155.505; and (5) 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)).

Your appeal was requested to dispute your health plan retroactively charging you an additional premium, and not your eligibility for financial assistance, or the start date of your bronze-level qualified health plan. This issue relates to your health plan costs and premiums decided upon by your health plan, which is not an issue that the NYSOH Appeals Unit is authorized to address. Therefore, we must dismiss your appeal.

How does this Dismissal Affect Your Eligibility?

This decision does not change your current eligibility.

NYSOH Appeals Unit does not have authority to hear issues involving qualified health plan billing and payments. Therefore, your case is RETURNED to Plan Management to investigate whether or not your plan properly billed you for the months in which you and your child were entitled to share in APTC.

If You Think Your Appeal Should Not Be Dismissed

If you think your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. In that writing, you must explain why you think this dismissal should be vacated and if your issue differs from the one discussed above.

If you ask us in writing to vacate this dismissal, NYSOH's Appeals Unit will review your request and send you a decision on that request.

If we deny your request to vacate this dismissal, we will tell you that in writing.

If you do not respond to this notice within 30 days, your appeal will remain dismissed. No further action will be taken on it by NYSOH.

Appeal Identification Number

When communicating with NYSOH about this appeal, please reference Appeal Identification Number and the Account ID at the top of this notice.

How to Contact NYSOH

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

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.530.

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A Copy of this Notice of Dismissal Has Been Provided To

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