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

Notice of Decision

Decision Date: February 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025153

[redacted]

[redacted]

On February 6, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 26, 2017 disenrollment 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 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: February 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025153

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Issue

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

> Does NY State of Health (NYSOH) Appeals Unit have the authority to review whether you are eligible to be reimbursed for the December 2017 premium that was paid to your child's health insurance company?

Procedural History

On August 23, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible to enroll in a full price Child Health Plus (CHP) or a Child-Only qualified health plan for limited time, effective October 1, 2017. You were requested to provide proof of your child's Social Security number and citizenship status by November 20, 2017 to confirm his eligibility.

Also on August 23, 2017, NYSOH issued an enrollment notice confirming your selection of a CHP plan for your child's enrollment as of August 22, 2017, with such coverage beginning October 1, 2017, with a monthly premium of $218.53.

On September 6, 2017, NYSOH issued an enrollment notice confirming that your child's CHP plan coverage start date had been modified to begin effective September 1, 2017, again with a monthly premium of $218.53.

On November 25, 2017, NYSOH redetermined your child's eligibility for financial assistance with health insurance.

On November 26, 2017, NYSOH issued an eligibility determination notice stating that your child was no longer eligible for health insurance through NYSOH because you did not provide proof of your child's Social Security number and citizenship status by November 20, 2017 due date.

Also on November 26, 2017, NYSOH issued a disenrollment notice confirming that your child's CHP plan coverage would end effective November 30, 2017.

On December 1, 2017, NYSOH received an update to your application for financial assistance with health insurance. In response to this application, NSYOH prepared a preliminary eligibility determination stating that your child was eligible for CHP at full cost, for a limited time, effective January 1, 2018.

Also on December 1, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal relative to the end of your child's CHP coverage.

On December 2, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for CHP at full cost, for a limited time, effective January 1, 2018. You were requested to provide proof of your child's Social Security number and citizenship status by March 1, 2018 to confirm his eligibility.

Also on December 2, 2017, NYSOH issued an enrollment notice confirming the selection of your child's CHP plan as of December 1, 2017, with such coverage to begin effective January 1, 2018, with a monthly premium of $218.53.

On December 12, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On December 13, 2017, NYSOH issued an eligibility determination notice stating that your child was eligible for CHP at full cost, without condition, effective January 1, 2018.

On February 6, 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) According to your NYSOH account, your child's date of birth is [redacted]

2) The application that was submitted on August 22, 2017 indicates that he was a US citizen and had a Social Security number.

3) In response to your August 22, 2017 application, NYSOH issued an eligibility determination notice stating that your child was eligible for CHP at full cost, effective October 1, 2017, but requested proof of your child's Social Security number and citizenship status by November 20, 2017 to confirm his eligibility.

4) According to your NYSOH account and testimony, your child was enrolled in a CHP plan through Healthfirst, with a start date of October 1, 2017, which was later modified to September 1, 2017.

5) You child was disenrolled from his CHP plan effective September 30, 2017 for failure to provide proof of his Social Security number and citizenship status by the due date.

6) You testified, and the record reflects, that you receive all your notices from NYSOH by electronic mail.

7) You testified that you did not receive any electronic alerts regarding any notice in your NYSOH account telling you that you needed to provide additional information to confirm your child's eligibility for his CHP plan.

8) On December 1, 2017, NYSOH received your child's updated application for health insurance.

9) You testified that while you originally appealed seeking a reinstatement of your child's coverage during December 2017, you were no longer seeking his reinstatement since he did not incur any medical expenses during that month. You further testified that you were now seeking a reimbursement of the $218.53 you paid for his coverage during the month of December 2017, but did not receive.

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 the Appeals Unit of NYSOH: (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 the Exchange to provide timely notice of an eligibility determination; and (4) the denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.420(d)).

Legal Analysis

The issue under review is whether NYSOH Appeals Unit has the authority to review whether you are eligible to be reimbursed for the December 2017 premium amount that was paid to your child's health insurance company.

You testified that you were no longer seeking reinstatement of your child's coverage during the month of December 2017, but rather reimbursement of the premium you paid for coverage during that month.

You testified that you paid Healthfirst $218.53 for your child's December 2017 coverage and want to be reimbursed for that payment since he ultimately did not receive that coverage.

The 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 by the Exchange to provide timely notice of an eligibility determination, and (4) a denial of a request to vacate dismissal made by the NYSOH Appeals Unit.

The Appeals Unit does not have the authority to review whether an individual should be reimbursed for a premium paid to a health plan. We cannot reach the merits as to whether you are entitled to be reimbursed for that payment. Therefore, your request for reimbursement for the amount paid to the health insurance company for your children's coverage during the month of December 2017 is DISMISSED as a non-appealable issue.

However, Healthfirst may be able to help you with your request for reimbursement of the premium you paid for a period for which your child had no coverage. If you have not already been assisted by them, please contact them directly at 1-866-463-6743.

The Appeals Unit will also forward this case to NYSOH's Plan Management Unit.

In addition, since your issue concerns a health insurer and/or payment, reimbursement, coverage, benefits, rates and premiums, you can contact NY Department of Financial Services at their Consumer Hotline at (800) 342-3736 (Monday through Friday, 8:30 AM to 4:30 PM); or locally to (212) 480-6400; or you can file a complaint at http://www.dfs.ny.gov/consumer/fileacomplaint.htm

Decision

Your appeal of the November 26, 2017 disenrollment notice is DISMISSED as a non-appealable issue.

Effective Date of this Decision: February 26, 2018

How this Decision Affects Your Eligibility

Your child's eligibility remains unchanged. However, this is being forwarded to NYSOH's Plan Management Unit to assist you in communicating with your plan.

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 case 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.

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

Summary

Your appeal of the November 26, 2017 disenrollment notice is DISMISSED as a non-appealable issue.

Your child's eligibility remains unchanged. However, this is being forwarded to NYSOH's Plan Management Unit to assist you in communicating with your plan.

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।

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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 महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई 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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