



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

Notice of Decision

Decision Date: May 23, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015166

[REDACTED]

Dear [REDACTED],

On April 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 2017 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: May 23, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000015166

[REDACTED]

Issue

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

Did NY State of Health (NYSOH) properly determine that your enrollment in a qualified health plan (QHP) was effective February 1, 2017?

Procedural History

On October 14, 2016, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that, based on information from federal and state sources, NYSOH could not determine whether you would qualify for financial help paying for your health coverage, and that you needed to update your account by December 15, 2016 or you might lose the financial assistance you were currently receiving.

No updates were made to your account by December 15, 2016.

On December 19, 2016, NYSOH issued an eligibility determination notice stating that you were not eligible for Medicaid, Child Health Plus, or to receive tax credits or cost-sharing reductions to help pay for the cost of insurance. You also could not enroll in a QHP at full cost. This was because you had not responded to the renewal notice and had not completed your renewal within the required time frame. Your eligibility ended January 1, 2017.

Also on December 19, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your QHP was ending, effective December 31, 2016, because you were no longer eligible to enroll in health insurance through NYSOH.

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On January 6, 2017, NYSOH received your updated application for health insurance including that you were [REDACTED] with a due date of [REDACTED].

On January 7, 2017, NYSOH issued a notice of eligibility redetermination stating that you were conditionally eligible for Medicaid. This eligibility was effective January 1, 2017.

On January 17, 2017, you updated your NYSOH account.

On January 18, 2017, NYSOH issued a notice of eligibility determination, stating that you were eligible to receive up to \$221.00 per month in advance payments of the premium tax credit (APTC), effective February 1, 2017.

Also on January 18, 2017, NYSOH issued a letter confirming your enrollment in a QHP, effective February 1, 2017.

On January 25, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination and enrollment confirmation, insofar as they began your eligibility for enrollment in a QHP on February 1, 2017, and not January 1, 2017.

On April 19, 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 testified that you received the October 14, 2016 renewal notice from NYSOH telling you that you needed to update the information in your NYSOH account to ensure that your coverage would not be interrupted and that your financial assistance would continue.
- 2) You testified that you received several notices from NYSOH, including the October 14, 2016 renewal notice. You testified that you did not read through all the notices you received from NYSOH. You testified that, because you did not read the notices from NYSOH, you did not know that you had to update your account by December 15, 2016.
- 3) You testified that you did not know you needed to renew your application until you were advised by your doctor's office in January 2017 that you

had Medicaid Fee-for-Service coverage and not coverage through your QHP.

- 4) You updated the information in your NYSOH account on January 6, 2017. Also, on that date you indicated on your account that you were pregnant with one child with a due date of [REDACTED].
- 5) You testified that, because you were pregnant, you were determined eligible for Medicaid Fee-for-Service coverage for the month of January 2017.
- 6) You testified that your doctor would not accept Medicaid Fee-for-Service coverage for medical appointments in January 2017 and that is the reason that you are appealing the start date of your QHP.
- 7) You testified that you are only appealing your eligibility, and you are seeking for your QHP start date to be backdated from February 1, 2017 to January 1, 2017.

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

Applicable Law and Regulations

Annual Eligibility Redetermination

Generally, NYSOH must conduct annual eligibility redeterminations for qualified individuals who are seeking financial assistance through insurance affordability programs for the upcoming year, such as tax credits and cost-sharing reductions, Medicaid, or Child Health Plus. In such cases, NYSOH is required to request that the qualified individual provide updated income and family size information for use in an eligibility redetermination for the upcoming year (see 45 CFR § 155.335(a) and (b)).

NYSOH must send an annual renewal notice that contains the information by which NYSOH will use to redetermine a qualified individual's projected eligibility for that year (45 CFR § 155.335(c)(3)). If a qualified individual does not respond to the notice after a 30-day period, NYSOH must redetermine that individual's eligibility using the information and projected eligibility provided in the annual renewal notice (45 CFR § 155.335(g), (h)). NYSOH must ensure this redetermination is effective on the first day of the coverage year or in accordance with the rules specified in 45 CFR § 155.330(f) regarding effective dates, whichever is later (45 CFR § 155.335(i)). The rules specified in 45 CFR § 155.330(f) are not pertinent here.

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Redetermination During a Benefit Year

When an eligibility redetermination results in a change in the amount of APTC for a part of the benefit year, NYSOH must recalculate the amount of APTC in such a manner as to account for any advance payments already made (or not made) on behalf of the tax filer, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the overall benefit year (45 CFR § 155.330(g)).

Any change resulting from redeterminations during a benefit year should be made effective the first day of the month following the date of the notice of redetermination, except that redeterminations resulting from changes made after a date specified by the state, which can be no earlier than the 15th of the month, may not be made effective until the first day of the month after the month following the date of the notice of redetermination. (45 CFR § 155.330(f)(1) and (2)).

However, upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective the first day of the month following the date of the notice, regardless of whether this occurred before or after the 15th of the month (45 CFR § 155.310(f), 45 CFR § 155.330(e), (f)(1)(i)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your eligibility for, and enrollment in, a QHP was effective no earlier than February 1, 2017.

NYSOH must redetermine a qualified individual's eligibility for health insurance and financial assistance to help pay for that health insurance annually. NYSOH must issue a renewal notice that contains the individual's projected eligibility. If an individual does not respond to this notice, NYSOH must issue an eligibility determination for the upcoming coverage year based on the information contained in the renewal notice.

On October 14, 2016, NYSOH issued an annual renewal notice in your case. That notice stated that based on information from federal and state sources, NYSOH could not determine whether you would qualify for financial help with paying for your health coverage. You were asked to update the information in your account by December 15, 2016 or the financial help you were receiving might end.

Because there was no timely response to this notice, your enrollment in a qualified health plan was terminated effective December 31, 2016.

You testified that you received the October 14, 2016 notice from NYSOH telling you that you needed to update the information in your NYSOH account. You testified that you had several notices from NYSOH including the October 14, 2016 renewal notice. You testified that you did not read through all the notices you received from NYSOH. You testified that because you did not read the notices from NYSOH, you did not know that you had to update your account by December 15, 2016.

Therefore, the record reflects that NYSOH properly notified you of your annual renewal and that information in your NYSOH account needed to be updated to ensure your enrollment in your health plan and eligibility for financial assistance would continue.

The record shows that on January 6, 2017 you updated the information in your NYSOH account. That day, you were found conditionally eligible for Medicaid as of January 1, 2017, pending documentation of your income. On January 17, 2017, you updated your NYSOH application again, and changed your household's annual expected income from \$55,000.00 to \$85,000.00. As a result, you were found eligible to enroll in a QHP and to receive APTC. Also on January 17, 2017, you submitted a request to enroll in a qualified health plan.

When an individual changes information in their application which results in a change in APTC eligibility, NYSOH must make the change in APTC effective the first day of the following month.

Therefore, NYSOH's January 18, 2017 eligibility determination and enrollment confirmation notices are AFFIRMED because they properly began your eligibility for APTC, and your enrollment in your QHP, on February 1, 2017.

Decision

The January 18, 2017 eligibility determination and enrollment confirmation notices are AFFIRMED.

Effective Date of this Decision: May 23, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

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).

Your eligibility for APTC, and your enrollment in your QHP, properly began as of February 1, 2017.

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

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- By mail at:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The January 18, 2017 eligibility determination and enrollment confirmation notices are **AFFIRMED**.

This decision does not change your eligibility.

Your eligibility for APTC, and your enrollment in your QHP, properly began as of February 1, 2017.

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।

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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 sre wo, fre 1-855-355-5777. ye&etumi ama wo obi a okyerE 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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