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

# Notice of Decision

Decision Date: June 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016118

[redacted]

Dear [redacted],

On May 31, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 15, 2016, and February 18, 2017 eligibility determination 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 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.

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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DEPARTMENT OF HEALTH
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# Decision

Decision Date: June 29, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016118

[redacted]

## Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health (NYSOH) properly determine that you were eligible to purchase a qualified health plan at full cost, effective January 1, 2017?
>
> Did NY State of Health properly determine the application of advance payments of the premium tax credit and cost sharing reductions were effective no earlier than April 1, 2017?

## Procedural History

On December 14, 2016, NY State of Health (NYSOH) received your application for financial assistance.

On December 15, 2016, an eligibility determination notice was issued stating you were eligible to purchase a qualified health plan at full cost, effective January 1, 2017. The notice further stated that you were not eligible to receive advance premium tax credits (APTC) because you were already enrolled in or eligible for minimum value employer sponsored insurance and you were not eligible for cost-sharing reductions because you were not eligible for APTC.

On December 15, 2016, an enrollment notice was issued confirming your enrollment on December 14, 2016, in a Bronze level qualified health plan with a premium responsibility of $358.71 per month starting January 1, 2017.

On February 13, 2017, you uploaded a copy of your termination letter from your parent's employer sponsored health insurance. See [redacted].

On February 17, 2017, NYSOH received your updated application for financial assistance.

On February 18, 2017, an eligibility determination notice was issued stating you were eligible for advance payments of the premium tax credit of up to $320.00 per month as well as cost-sharing reductions if you enrolled in a silver level qualified health plan, effective April 1, 2017.

On February 18, 2017, a disenrollment notice was issued stating your enrollment in your Bronze level qualified health plan would end on March 31, 2017.

Also on February 18, 2017, an enrollment notice was issued confirming your enrollment in a Silver level qualified health plan with a premium responsibility of $126.10 per month starting April 1, 2017.

On February 22, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of the start date of your APTC insofar as it was not effective as of January 1, 2017.

On May 31, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open 15 days for you to provide proof of the cost of your parent's employer sponsored insurance. At the end of the close of the record, no documentation was received by NYSOH Appeals Unit or viewable in your account. Therefore, the record will be considered complete and closed as of the date of your telephone hearing.

## Findings of Fact

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

1) You are appealing your eligibility.

2) The application that was filed on December 14, 2016, stated you were enrolled in your mother's employer sponsored insurance effective October 1, 2016, but with no coverage end date selected.

3) The application you submitted on December 14, 2016, listed an annual expected household income of $24,392.00 with a tax filing status of single.

4) The record supports you submitted your application online.

5) You enrolled in a full cost Bronze level qualified health plan on December 14, 2016, with an effective date of January 1, 2017.

6) You testified that you were enrolled in your parents' employer sponsored health insurance until December 31, 2016, as you [redacted] in December, and could no longer remain enrolled in that plan.

7) You did not provide evidence of what your mother's employer sponsored insurance plan would cost for an individual.

8) On February 13, 2017, you uploaded a copy of your January 1, 2017, termination letter from your parent's employer sponsored health insurance showing an end date of January 1, 2017. See [redacted].

9) You submitted an updated application to NYSOH for financial assistance on February 17, 2017.

10) You testified, and the record reflects, that you selected a silver level qualified health plan on February 17, 2017.

11) Your enrollment in the plan became effective April 1, 2017, as well as the application of cost sharing reductions and advance premium tax credits of up to $320.00 per month.

12) You testified that you would like your eligibility for financial assistance to begin on January 1, 2017 because you paid full price for your Bronze level qualified health plan.

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

## Applicable Law and Regulations

Advance Payments of the Premium Tax Credit

An APTC is available to a person who is eligible to enroll in a qualified health plan and

1. expects to have a household income between 138% and 400% of the Federal Poverty Line (FPL),

2. expects to file a tax return and claim a personal exemption deduction for a person who meets the eligibility requirements to enroll in a qualified health plan, and

3. is not otherwise eligible for minimum essential coverage except through the individual market (45 CFR § 155.305(f)).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Redetermination During a Benefit Year

When a redetermination is issued as a result of a change in an applicant's information, NYSOH must generally make that redetermination effective on the first day of the month following the date NYSOH is notified of the change (45 CFR § 155.330 (f)(1)(ii)). However, NYSOH may determine that its policy will be that any change made after the 15th of any month will not be effective until the first of the second following month (45 CFR § 155.330(f)(2)).

When an eligibility redetermination results in a change in the amount of advance payments of the premium tax credit (APTC) for the benefit year, NYSOH must recalculate the amount of APTC in such a manner as to account for any advance payments already 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 that benefit year (45 CFR § 155.330(g)).

Enrollment in a Qualified Health Plan

The effective date of coverage by a qualified health plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i)). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

## Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible to purchase a qualified health plan at full cost effective January 1, 2017.

In the eligibility determination notice issued on December 15, 2016, NYSOH denied you advance payments of the premium tax credits because you were eligible for or enrolled in health insurance coverage.

An employee or a related individual to the employee, who is eligible to enroll in an employer-sponsored health insurance plan that is affordable and provides minimum value, is not eligible for advance premium tax credits through NYSOH.

During the hearing, you testified that were enrolled in employer-sponsored insurance through your mother's employer. However, since you were [redacted] in December, of 2016, you were no longer eligible to remain enrolled in that health plan effective December 31, 2016.

The application you filed on December 14, 2016, indicated you were enrolled in an employer sponsored insurance plan with a start date of October 1, 2016, but with no coverage end date selected.

The eligibility determination relied on this information and reviewed your eligibility as if you were enrolled still with that plan.

Since based on your application, you were eligible for and enrolled in minimum essential coverage outside of NYSOH, the December 15, 2016, eligibility determination is correct and is AFFIRMED.

The second issue under review is whether NYSOH properly determined the application of your APTC and cost sharing reductions were effective no earlier than April 1, 2017.

On February 13, 2017, you provided a copy of your termination letter showing the end date of your coverage under your mother's employer sponsored health insurance effective January 1, 2017. You then updated the information in your NYSOH account on February 17, 2017, and submitted a request to enroll in a silver level qualified health plan. On February 18, 2017, NYSOH issued an enrollment confirmation notice stating that your enrollment in your qualified health plan was effective April 1, 2017 and that APTC and cost sharing reductions would be applied to your monthly premium effective April 1, 2017.

When an individual changes information in their application on or before the 15th of any month, NYSOH must make the redetermination that results from the change effective the first day of the following month. Changes which are made after the 15$^{th}$ of the month are effective the first day of the second following month.

Although you provided the documentation showing the end date of your third-party health insurance on February 13, 2017, you did not update your application and select your silver level health plan coverage until February 17, 2017.

Therefore, NYSOH's February 18, 2017, eligibility determination notice and enrollment confirmation notice are AFFIRMED because it properly began your APTC and cost sharing reductions on April 1, 2017.

## Decision

The December 15, 2016, eligibility determination stating you were eligible to purchase a qualified health plan at full cost January 1, 2017 is AFFIRMED.

The February 18, 2017 eligibility determination notice stating you were eligible for advance premium tax credits and cost sharing reductions effective April 1, 2017 is AFFIRMED.

## Effective Date of this Decision: June 29, 2017

## How this Decision Affects Your Eligibility

Your eligibility for advance premium tax credits and cost-sharing reductions are effective April 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
- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

## Summary

The December 15, 2016, eligibility determination stating you were eligible to purchase a qualified health plan at full cost January 1, 2017 is AFFIRMED.

The February 18, 2017 eligibility determination notice stating you were eligible for advance premium tax credits and cost sharing reductions effective April 1, 2017 is AFFIRMED.

Your eligibility for advance premium tax credits and cost-sharing reductions are effective April 1, 2017.

## Legal Authority

We are issuing this determination in accordance with 45 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).

## A Copy of this Decision Has Been Provided To:

[redacted]

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)**

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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।

**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 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 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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