



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

## Notice of Decision

Decision Date: June 09, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016163

[REDACTED]

Dear [REDACTED],

On May 31, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 27, 2016 enrollment 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: June 09, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016163

[REDACTED]

## Issues

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

Was your appeal of NY State of Health's October 27, 2016 enrollment notice timely?

Did NY State of Health properly determine that your enrollment in a qualified health plan and the application of advance payments of the premium tax credit were effective, December 1, 2016?

## Procedural History

On December 1, 2015, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible for Medicaid, effective November 1, 2015.

On December 2, 2015, NYSOH issued a notice of enrollment confirming your enrollment in a Medicaid Managed Care plan with a plan enrollment start date of January 1, 2016.

On September 3, 2016, NYSOH issued a renewal notice advising you that you were eligible for up to \$83.39 per month in advance payments of the premium tax credit (APTC), effective November 1, 2016. This notice further advised you that you must select a different plan between September 16, 2016 and October 15, 2016.

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On September 18, 2016, NYSOH issued a disenrollment notice, advising that your enrollment in your Medicaid Managed Care plan was ending, effective October 31, 2016, as you were no longer eligible to remain enrolled in your current health plan.

Also on September 18, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to \$83.39 per month in APTC, effective November 1, 2016, and that you had been granted a special enrollment period through December 31, 2016.

On October 27, 2016, NYSOH issued an enrollment confirmation notice, based on your plan selection on October 26, 2016, stating that you were enrolled in your qualified health plan with a plan enrollment start date of December 1, 2016.

On November 11, 2016, a complaint (██████████) was created regarding the issue of the start date of your qualified health plan. On November 18, 2016, a duplicate complaint (#██████████) was created with regard to this same issue. On November 30, 2016, these complaints were combined into a third complaint (██████████) regarding the start date of your qualified health plan. This third complaint shows that on December 19, 2016 your qualified health plan was backdated to start on November 1, 2016, and that on December 20, 2016, you were informed of this resolution.

On December 20, 2016, another complaint (██████████) was created regarding your request to cancel coverage for November 2016. This complaint shows that on December 28, 2016 NYSOH declined your request.

On February 14, 2017, you spoke to NYSOH's Account Review Unit and appealed this determination insofar as you were enrolled in a qualified health plan for November 2016. However, the Account Review Unit filed this appeal in another account of which, you are the account holder. On February 23, 2017, the Account Review Unit transferred the appeal information to the account at issue.

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 closed at the end of the hearing.

## **Findings of Fact**

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

- 1) On September 16, 2016, NYSOH redetermined your eligibility for financial assistance with health insurance.

- 2) You testified, and your NYSOH account reflects, that on October 26, 2016 you selected a qualified health plan for enrollment.
- 3) Your enrollment in the qualified health plan became effective December 1, 2016.
- 4) The record reflects that on November 11, 2016 a complaint ( [REDACTED] ) was filed regarding the start date of your qualified health plan.
- 5) On November 30, 2016, another complaint ( [REDACTED] ) was created regarding the issue of the start date of your qualified health plan. This complaint shows that on December 19, 2016 your qualified health plan was backdated to start on November 1, 2016, and on December 20, 2016 you were informed of the granted backdate for your qualified health plan.
- 6) You testified that you never received any written notice that your qualified health plan would begin on November 1, 2016.
- 7) No notices are contained in your NYSOH indicating that your qualified health plan would begin on November 1, 2016.
- 8) On December 20, 2016, another complaint ( [REDACTED] ) was created wherein you requested to cancel your coverage for November 2016. This complaint shows resolution on December 28, 2016 at which time, NYSOH declined your request.
- 9) You testified that you are seeking to have no enrollment for November 2016 as you were unable to use your coverage for that month as your request for November 2016 coverage was not granted until December 19, 2016.

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 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)).

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH (45 CFR §155.520(b)(2); 18 NYCRR 358-3.5(b)(1)).

However, where an appeal request is untimely, the appeal request may be considered valid if the applicant or enrollee sufficiently demonstrates within a reasonable timeframe as determined by NYSOH that failure to timely submit the appeal was due to exceptional circumstances and should not preclude the appeal (45 CFR §155.520(d)(2)(i)(D)).

### 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 15<sup>th</sup> 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)).

### Notice of Decision Concerning Eligibility

NYSOH must issue a written notice of eligibility for every application unless such application has been withdrawn, the applicant has died, or the application cannot be located (42 CFR §600.330(e)).

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).

## Legal Analysis

The first issue under review is whether your appeal of NYSOH's October 27, 2016 enrollment notice was timely.

The record reflects that your first contacted NYSOH to file a formal appeal on February 14, 2017, however, the Account Review Unit filed the appeal in a different account, and transferred the appeal to the account at issue on February 23, 2017.

Individual applicants and enrollees must request a hearing within sixty (60) days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of your enrollment and disenrollment from your qualified health plan, an appeal should have been filed by January 5, 2017. The record reflects that you filed your appeal on February 14, 2017, which is beyond the 60-day deadline.

Although your appeal was untimely on its face, the record reflects that you contacted NYSOH on November 11, 2016, November 18, 2016, November 30, 2016, and December 20, 2016. Additionally, the complaint created on December 20, 2016, which was within the 60-day time frame to appeal, was not noted as being resolved until December 28, 2016.

As you filed a formal appeal on February 14, 2017, which was within 60 days of the resolution of the December 20, 2016 incident, your appeal was timely and will be addressed.

The second issue under review is whether NYSOH properly determined that your enrollment in a qualified health plan was effective December 1, 2016.

The record shows that on October 26, 2016 you submitted a request to enroll in a qualified health plan. On October 27, 2016 NYSOH issued a notice of enrollment confirmation stating that your enrollment in your qualified health plan was effective December 1, 2016.

The date on which a qualified health plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected after the fifteenth day of a month goes into effect on the first day of the second following month.

Therefore, NYSOH's October 27, 2016 enrollment confirmation notice is **AFFIRMED** because it properly began your enrollment in your qualified health plan on December 1, 2016.

On December 19, 2016, NYSOH backdated your enrollment in your qualified health plan to November 1, 2016. You have requested that this be rescinded.

NYSOH did not provide you with proper written notice of this eligibility determination, which prevented you from being able to use your coverage in November 2016. Therefore, the informal resolution contained in complaint [REDACTED] is RESCINDED and the matter is RETURNED to NYSOH to disenroll you from your qualified health plan for November 2016.

## **Decision**

The October 27, 2016 enrollment notice is AFFIRMED.

Resolution of complaint [REDACTED] is RESCINDED.

Your case is RETURNED to NYSOH to disenroll you from your qualified health plan for the month of November 2016.

**Effective Date of this Decision:** June 09, 2017

## **How this Decision Affects Your Eligibility**

Your case is being sent back to NYSOH to disenroll you from your qualified health plan for the month of November 2016.

## **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 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 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 October 27, 2016 enrollment notice is AFFIRMED.

Resolution of complaint [REDACTED] is RESCINDED.

Your case is RETURNED to NYSOH to disenroll you from your qualified health plan for the month of November 2016.

### **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:**



## 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&btumi 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 דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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