



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

## Notice of Decision

Decision Date: September 18, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000018494

[REDACTED]

Dear [REDACTED],

On September 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 8, 2017 eligibility determination notice, March 30, 2017 disenrollment notice and April 21, 2017 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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DEPARTMENT OF HEALTH  
P.O. Box 11729  
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## Decision

Decision Date: September 18, 2017

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

[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 eligibility for advance payments of the premium tax credit ended effective April 1, 2017?

Did NYSOH properly determine that you were no longer eligible for health insurance through NYSOH, effective May 1, 2017?

Did NYSOH properly determine that your Essential Plan coverage began effective June 1, 2017?

## Procedural History

On December 2, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to receive payments of the advance premium tax credit (APTC) of up to \$271.00 per month and, if you selected a silver-level plan, eligible to receive cost-sharing reductions (CSR) for a limited time, effective January 1, 2017. The notice further directed you to provide documentation confirming your income before March 1, 2017.

Also on December 2, 2016, NYSOH issued a notice confirming your enrollment in a qualified health plan (QHP) with APTC and cost-sharing reductions, effective January 1, 2017. The notice stated that your monthly premium would be \$128.59, after applying the \$271.00 APTC.

On March 8, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a QHP at full cost. The notice stated that you were not eligible to receive APTC or cost-sharing reductions because NYSOH did not receive the income documentation needed to verify the income listed in your application. This eligibility was effective April 1, 2017.

Also on March 8, 2017, NYSOH issued an enrollment confirmation notice stating that you remained enrolled in your QHP, and that your monthly premium would be \$399.59, after applying an APTC of \$0.00.

On March 29, 2017, NYSOH received an update to your application for health insurance. This application update reflected that you were no longer applying for health coverage since you obtained a plan having minimum essential coverage outside of NYSOH.

On March 30, 2017, NYSOH issued an eligibility determination notice stating that you were no longer eligible for health coverage through NYSOH since you no longer wanted to receive coverage.

Also on March 30, 2017, NYSOH issued a disenrollment notice stating that your QHP coverage would end effective April 30, 2017.

On April 20, 2017, NYSOH received an update to your application for health insurance.

Also on April 20, 2017, NYSOH received (1) your 2016 Social Security Benefit Statement (Form SSA-1099), and (2) a notice of award issued by the Social Security Administration, dated April 20, 2017, reflecting that your monthly benefit beginning December 2016 and your entitlement to Medicare beginning July 2017.

On April 21, 2017, NYSOH issued an eligibility determination notice based on the information contained in your April 20, 2017 application. The notice stated that you were eligible to enroll in the Essential Plan with a \$20.00 per month premium, effective June 1, 2017.

Also on April 21, 2017, NYSOH issued an enrollment notice confirming your selection of an Essential Plan for your coverage on April 20, 2017. The notice also stated that your Essential Plan coverage would begin effective June 1, 2017.

On April 28, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your APTC as of April 1, 2017, and were seeking for your Essential Plan coverage to begin effective May 1, 2017.

On June 13, 2017, NYSOH received an update to your application for health insurance. This application reflected that you were no longer seeking coverage

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through NYSOH since you obtained minimum essential coverage outside of NYSOH.

On June 14, 2017, NYSOH issued a disenrollment notice confirming that your Essential Plan coverage would end effective June 30, 2017.

On September 8, 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) Your NYSOH account confirms that you receive alerts of your notices from NYSOH by electronic mail.
- 2) You testified that you did not receive any electronic alerts notifying you of any notice in your NYSOH account stating that your APTC eligibility was only conditional and that you needed to provide documentation of your income by March 1, 2017.
- 3) You testified that you believed your election to receive notices would result in you receiving both electronic alerts and regular mail notices, but that was not the case.
- 4) You testified that you did not know that you needed to submit documentation of your income until your premium had increased from \$128.59 to \$399.59 for coverage during the month April 1, 2017.
- 5) Your NYSOH account indicates that on March 7, 2017 your application was run and you were found no longer eligible for APTC as of April 1, 2017.
- 6) You updated your application on March 29, 2017, in which you changed your application type to "Non-Financial Assistance." You attested in that application to not applying for health insurance because you had minimum essential coverage outside of NYSOH.
- 7) Your coverage under your QHP, at your election, was ended effective April 30, 2017.
- 8) You submitted income documentation to NYSOH on April 20, 2017, which included (1) your 2016 Social Security Benefit Statement (Form SSA-1099), and (2) a notice of award issued by the Social Security

Administration, dated April 20, 2017, reflecting that your monthly benefit beginning December 2016 and your entitlement to Medicare beginning July 2017.

- 9) You further updated the income information in your NYSOH account on April 20, 2017.
- 10) You were found eligible for coverage under the Essential Plan with a \$20.00 monthly premium, effective June 1, 2017.
- 11) You testified that you were seeking a backdate of your Essential Plan coverage to May 1, 2017, not because you were seeking reimbursement for out-of-pocket medical expenses, but rather on principle.

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

## **Applicable Law and Regulations**

### Verification of Eligibility for Advance Payments of the Premium Tax Credit

APTC are generally 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 applicable federal poverty level (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 (see 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

An applicant is required to attest to their household's projected annual income for purposes of determining their eligibility for APTC (45 CFR § 155.320(c)(3)(ii)(B)). For all individual's whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective as of the first day of the month following the date of the notice (45 § 155.310(f), 45 CFR § 155.330(e), (f)(1)(i)).

### Electronic Notices

Applicants may choose to receive notices and information from NYSOH by either electronic or regular mail. If the individual elects electronic communications, NYSOH must send an email or other electronic communication alerting the individual when a notice has been posted to his or her account and send a notice by regular mail within three business days if the electronic communication cannot be delivered (45 CFR § 155.230(d); 42 CFR § 435.918(b)(4), (5)).

### Termination of a Qualified Health Plan

NYSOH must permit an enrollee to terminate his or her coverage with a qualified health plan coverage, with appropriate notice to the NYSOH or qualified health plan (45 CFR § 155.430(b)(1)(i)).

For enrollee-initiated terminations, the last day of coverage is either:

- 1) The termination date specified by the enrollee, if the enrollee provides reasonable notice (at least 14 days before the requested termination date);
- 2) Fourteen days after the enrollee requests the termination, if they do not provide reasonable notice; or
- 3) On a date on or after the date the enrollee requests the termination, if the enrollee's qualified health plan issuer and the enrollee agree to such a date

(45 CFR § 155.430(d)(2)(i)-(iii)).

## Essential Plan Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

The effective date of coverage by an Essential 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); see also 42 CFR § 600.320). 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 issue under review is whether NYSOH properly determined that your eligibility for APTC ended effective April 1, 2017.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to his or her household's projected annual income. For individuals seeking APTC, NYSOH must request income data from federal data sources to verify an individual's income attestation.

If NYSOH cannot verify an individual's attestation, it must provide the individual with notice of the inconsistency and provide a period of 90 days from the date notice is received to resolve the inconsistency.

In the eligibility determination issued on December 2, 2016, you were advised that your eligibility for APTC was only conditional, and that you needed to confirm your household's income before March 1, 2017.

The record reflects that NYSOH did not receive the requested income documentation before the deadline.

However, the record reflects that you elected to receive alerts regarding notices from NYSOH electronically. You credibly testified that you did not receive any electronic alert regarding the eligibility determination notice, which advised you that your eligibility was only conditional and that you needed to submit documentation to confirm your income.



There is also no evidence in your account documenting that any email alert was sent to you regarding the need to submit documentation, or that the notice was later sent to you by regular mail.

Therefore, it is concluded that NYSOH did not give you the proper notice that you needed to submit documentation of your income to confirm your eligibility for APTC.

Since you were not made aware of and did not receive proper notice that there was an inconsistency in your NYSOH account, the March 8, 2017 eligibility determination stating that you are no longer eligible for APTC because you failed to submit documentation is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your APTC during the month of May 2017.

The second issue is whether NYSOH properly determined that you were no longer eligible for health insurance through NYSOH, effective May 1, 2017.

Enrollees must be allowed to terminate their coverage with a QHP at the date they specify if they provide reasonable notice to NYSOH or to their health plan. Reasonable notice is defined as at least 14 days prior to the requested termination date.

The record reflects that on March 29, 2017, you updated your application in which you changed your application type to "Non-Financial Assistance." You attested in that application to not applying for health insurance because you had minimum essential coverage outside of NYSOH.

Accordingly, NYSOH properly disenrolled you from your QHP, effective April 30, 2017.

Therefore, the March 30, 2017 disenrollment notice confirming that your QHP coverage ended effective April 30, 2017 is AFFIRMED.

The third issue is whether NYSOH properly determined that your reenrollment in the Essential Plan was effective June 1, 2017.

You testified, and the record indicates, that you updated your NYSOH application on April 20, 2017. As a result, you were found eligible for the Essential Plan as of April 20, 2017 and enrolled into a plan that day.

The date on which enrollment in an Essential Plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

On April 20, 2017, you selected an Essential Plan, so your enrollment properly took effect on the first day of the second month following April 2017; that is, on June 1, 2017.

Therefore, the April 21, 2017 enrollment notice stating that your enrollment in the Essential Plan was effective June 1, 2017, is correct and must be AFFIRMED.

## **Decision**

The March 8, 2017 notice of eligibility determination is RESCINDED.

Your case is RETURNED to NYSOH to reinstate your APTC for the month of April 2017.

The March 30, 2017 disenrollment notice is AFFIRMED.

The April 21, 2017 enrollment notice is AFFIRMED.

**Effective Date of this Decision:** September 18, 2017

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

NYSOH erred in terminating your APTC effective April 1, 2017, without the proper notice.

Your case is being sent back to NYSOH to reinstate your APTC during the month of April 2017.

Your QHP coverage ended effective April 30, 2017.

Your Essential Plan coverage began effective June 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.

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).

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

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## **Summary**

The March 8, 2017 notice of eligibility determination is RESCINDED.

NYSOH erred in terminating your APTC effective April 1, 2017, without the proper notice.

Your case is being sent back to NYSOH to reinstate your APTC during the month of April 2017.

The March 30, 2017 disenrollment notice is AFFIRMED.

Your QHP coverage ended effective April 30, 2017.

The April 21, 2017 enrollment notice is AFFIRMED.

Your Essential Plan coverage began effective June 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 مجاناً.

### 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 नि:शुल्क 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 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 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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