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

Notice of Decision

Decision Date: October 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020036

[redacted]

Dear [redacted]

On September 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 22, 2017 enrollment confirmation 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
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Decision

Decision Date: October 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020036

[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 oldest son's portion of the $1,078.00 in advance payments of the premium tax credits your household was eligible for, ended effective June 1, 2017?

Procedural History

On December 7, 2016, NYSOH received your household's application for financial assistance with your health insurance.

On December 8, 2016, NYSOH issued a notice of eligibility redetermination stating that you, your husband and your two sons were jointly eligible to receive up to $1,078.00 per month in advance payments of the premium tax credits (APTC) and, if you selected a silver-level qualified health plan, for cost-sharing reductions (CSR). This eligibility was effective January 1, 2017.

On December 13, 2016, NYSOH issued a letter confirming your household's enrollment in a qualified health plan with a monthly premium responsibility of $634.76 per month, after your household's APTC of $1,078.00 was applied, both effective January 1, 2017.

On May 22, 2017, NYSOH issued a disenrollment notice stating your oldest son's coverage in his silver level qualified health plan was ending on June 30, 2017. The notice stated his coverage was ending because the plan is only available to individuals who are 29 years of age or younger.

On May 22, 2017, NYSOH issued a letter confirming your, your husband, and your youngest son's enrollment in a qualified health plan with a monthly premium responsibility of $904.26 per month, after your APTC of $808.50 per month was applied. The notice stated your APTC would be applied to your monthly premium starting on July 1, 2017.

On June 6, 2017, NYSOH issued a notice of eligibility redetermination stating that you, your husband and your youngest son were eligible to receive up to $1,016.00 per month in APTC and, if you selected a silver-level qualified health plan, for CSR. This eligibility was effective July 1, 2017.

On June 6, 2017, NYSOH issued a letter confirming your enrollment in a qualified health plan with a monthly premium responsibility of $696.76 per month, after your APTC of $1,016.00 was applied, both effective July 1, 2017.

On June 26, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were charged a higher premium responsibility for the month of June 2017.

On September 18, 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 submitted an application to NYSOH for financial assistance on December 7, 2016.

2) You testified, and the record reflects, that you selected a silver level qualified health plan for your family on December 12, 2016.

3) You, your husband, and your two son's enrollment in a silver level qualified health plan became effective January 1, 2017.

4) Your oldest son was disenrolled from the qualified health plan, effective June 30, 2017.

5) The record supports your oldest son turned [redacted] in the month of June 2017.

6) You testified you were charged a higher premium responsibility of over $900.00 for the month of June 2017.

7) You testified your health plan could not explain to you why you were charged a higher premium amount of over $900.00 for the month of June 2017, when your change in APTC to the lower amount was to be effective July 1, 2017.

8) NYSOH issued a notice on May 22, 2017 that changed the APTC amount to $808.50 per month. The notice stated the change in your premium which increased to $904.26 per month would start on July 1, 2017.

9) You reside in Richmond County, NY.

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

Applicable Law and Regulations

APTC Redetermination During a Benefit Year

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)).

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)).

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)).

Young Adults Coverage Up to Age 29 on Parents' Plan

Once a dependent child reaches age 26 and "ages out" of his or her parents' coverage, they may have several options, including enrolling in an individual plan by themselves through NYSOH or under a family plan with an age 29 rider. Every

insurer issuing a policy of hospital, medical, or surgical expense insurance that provides coverage for dependent children must make available, an if requested by the policyholder extend coverage under the policy to an unmarried child through age 29 (NY Ins. Law §3216(a)(4)(C)).

Legal Analysis

The issue under review is whether NYSOH properly determined that your oldest son's portion of the $1,078.00 in advance payments of the premium tax credits your household was eligible for, ended effective June 1, 2017.

On December 7, 2016, NYSOH received your household's application for financial assistance for your, yourself, and your two sons. Based on that application you, your husband and your two sons were jointly eligible to receive up to $1,078.00 per month in APTC, effective January 1, 2017

You then enrolled your household in a qualified health plan with a monthly premium responsibility of $634.76 per month, after your APTC of $1,078.00 was applied, both effective January 1, 2017.

On May 22, 2017, NYSOH issued a disenrollment notice stating your oldest son would be disenrolled from the silver level qualified health plan your household had been enrolled in, effective June 30, 2017. The notice stated this was because the plan he was enrolled in was only available to individuals who are 29 years of age or younger.

NYSOH issued a letter on May 22, 2017 alerting you to the change in your husband and your youngest son's APTC confirming a new monthly premium responsibility of $904.26 per month, after your new level of APTC of $808.50 per month was applied. Since APTC is shared jointly among household members, NYSOH reduced the amount of APTC that was being applied to your premium by 1/4th since your oldest son was no longer eligible to be enrolled in that plan because of his age.

Adult children who are under the age of 30, may enroll in a family qualified health plan. Every insurer issuing a policy of hospital, medical, or surgical expense insurance that provides coverage for dependent children must make available, coverage under the policy to an unmarried child through age 29.

Since your oldest child [redacted] in June 2017, NYSOH determined that he would no longer be eligible to remain enrolled in a family qualified health plan and his enrollment in the plan would therefore correctly end as of June 30, 2017. However, the record reflects that NYSOH prematurely ended his share of APTC in that plan as of May 31, 2017 which resulted in the plan charging you a higher premium for the month of June 2017 because your oldest son's share of APTC

was no longer applied to the family plan's premium. However, since your son remained enrolled in the qualified health plan for the month of June 2017, his portion of APTC should have continued to be applied to the family premium during that month.

Therefore, since NYSOH's May 22, 2017, enrollment notice determined your APTC change to $808.50 per month incorrectly resulted in the change being effective June 1, 2017, it is RESCINDED.

Your case is RETURNED to NYSOH to ensure your household's application and eligibility of APTC up to $1,078.00 per month for the month of June 2017.

Decision

The May 22, 2017, enrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to ensure your household's application and eligibility of APTC up to $1,078.00 per month for the month of June 2017.

Effective Date of this Decision: October 13, 2017

How this Decision Affects Your Eligibility

Your household's eligibility for APTC up to $1,078.00 per month should have continued until June 30, 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 May 22, 2017, enrollment notice is RESCINDED.

Your case is RETURNED to NYSOH to ensure your household's application and eligibility of APTC up to $1,078.00 per month continued through the month of June, 2017.

Your household's eligibility for APTC up to $1,078.00 per month should have continued until June 30, 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:

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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