



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

Notice of Decision

Decision Date: February 07, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000024849

[REDACTED]

[REDACTED]

On January 25, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 5, 2017 eligibility determination notice and the November 5, 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
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Decision

Decision Date: February 07, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000024849

[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) and the application of advance payments of the premium tax credit (APTC) were effective no earlier than January 1, 2018?

Procedural History

On January 13, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for Medicaid, effective December 1, 2016.

On September 23, 2017, NYSOH issued a renewal notice stating that you were no longer eligible for Medicaid, the Essential Plan, or tax credits to help you pay for health insurance, but that you were eligible to purchase a QHP at full cost, effective December 1, 2017. This was because information from state and federal data sources showed that your household income was over \$47,520.00.

On November 4, 2017, you updated your NYSOH account. NYSOH's system indicates that this application was processed with a year preference of 2018.

On November 5, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for a limited time to receive up to \$341.00 per month in APTC, and eligible for cost-sharing reductions if you enrolled in a silver level QHP, effective January 1, 2018. The notice also directed you to submit documentation of your income by February 2, 2018.

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On November 15, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in a silver level QHP with a monthly premium of \$570.05 per month, after the application of your APTC of \$341.00, beginning January 1, 2018.

On November 27, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination and enrollment confirmation notices insofar as they began your financial assistance eligibility and enrollment in a QHP on January 1, 2018, and not on December 1, 2017

On January 25, 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 support the following findings of fact:

- 1) You were enrolled in Medicaid coverage beginning on December 1, 2016, and ending on November 30, 2017.
- 2) You submitted an updated application to NYSOH for financial assistance on November 4, 2017.
- 3) You testified that you knew that your Medicaid was ending on November 30, 2017, so you wanted to make sure to update your application in time to have coverage for December 2017.
- 4) You testified that you updated the application yourself online on November 4, 2017, and your NYSOH account reflects that you selected a plan for enrollment on that day as well.
- 5) You testified that you do not recall whether the application asked you at any point to select a year for which you wanted coverage.
- 6) Your NYSOH account reflects that the application filed on November 4, 2017 was processed with a year preference of 2018.
- 7) You testified that you received a notice in your NYSOH inbox stating that your coverage was not going to start until January 1, 2018.
- 8) You testified that you called NYSOH sometime around the end of November 2017 and were allowed to enroll in coverage for December 2017 through the same QHP in which you are currently enrolled.

- 9) A note entered in NYSOH's system on November 22, 2017 states, "Backdated Blue Shield Silver to 12/01/17."
- 10) You testified that you paid the full premium for your QHP for December 2017, which was over \$500.00, and that you would like to receive a tax credit for that month.
- 11) You testified that you plan to file your 2017 income tax return with a tax filing status of single, and will claim no dependents.
- 12) You testified that you received \$11,908.00 in Unemployment Insurance Benefits in 2017 between January and September. Your NYSOH account contains a 1099-G form for 2017 indicating that you received a total of \$11,996.00 in Unemployment Insurance Benefits in 2017 ([REDACTED] [REDACTED]).
- 13) You testified that you began a new job in September 2017, and that you submitted a W2 from that position.
- 14) Your NYSOH account contains a 2017 W2 from [REDACTED] [REDACTED] for total earnings of \$10,384.62 ([REDACTED]).
- 15) You testified that you also earn income from self-employment for [REDACTED] [REDACTED] that you do, and that you grossed approximately \$2,000.00 from that work in 2017.
- 16) You testified that you live in Rensselaer County.

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.

Redetermination During a Benefit Year

When a redetermination is issued because 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)).

Upon making an eligibility redetermination, NYSOH must notify the applicant, and it must implement any decreases in eligibility to receive APTC effective as of the first day of the month following the date of the notice if the change occurs on or before the 15th of the month; otherwise, the change becomes effective the first day of the second following month (45 CFR § 155.310(f), 45 CFR § 155.330(f)(1)(i) and (f)(3)). Increases become effective the first day of the following month, regardless of when during the month the change occurs (*id.*).

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)).

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Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a qualified health plan (QHP) 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 QHP, 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)).

The maximum amount of APTC that can be authorized equals:

- 1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

minus

- 2) the taxpayer's expected contribution amount

(see 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

In an analysis of APTC eligibility, the determination is based on the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested (45 CFR §§ 155.300(a), 155.305(f)(1)(i)). On the date of your application, that was the 2016 FPL, which is \$11,880.00 for a one-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

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Legal Analysis

The issue under review is whether NYSOH properly determine that your enrollment in a QHP, as well as the application of APTC, was effective no earlier than January 1, 2018.

You were found eligible for Medicaid as of December 1, 2016.

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. 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.

On September 23, 2017, NYSOH issued a renewal notice stating that you were newly eligible to purchase a QHP at full cost, effective December 1, 2017, based on information available from state and federal data sources. The notice also stated that, if you needed to make any changes to your application, you should do so between October 16, 2017 and November 15, 2017 for your new plan to be in effect December 1, 2017.

You testified that you were aware that your eligibility was ending on November 30, 2017. You testified that you were not sure whether you received the September 23, 2017 renewal notice, but that you updated your account on November 4, 2017 to ensure that you would have coverage on December 1, 2017. You also selected a QHP for enrollment on that day.

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. Additionally, the date on which a QHP 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 fifteenth day of a month goes into effect on the first day of the following month.

You updated your application on November 4, 2017, and selected a plan that same day. Therefore, your new eligibility and enrollment should have started on the first day of the following month: December 1, 2017.

However, NYSOH's system reflects that your November 4, 2017 application was processed with a "year preference" of 2018, which caused your eligibility and enrollment to begin as of January 1, 2018. You testified that you do not recall whether you were asked to select a year for which you wanted coverage when you updated your application on November 4, 2017. Moreover, you credibly testified that you were updating your application because you knew your current coverage was ending November 30, 2017, and you wanted to ensure that you

reenrolled for coverage for December 1, 2017. As such, it was reasonable for you to believe that updating your account on November 4, 2017 would prevent any gap in coverage for the month of December 2017.

Your NYSOH account reflects that your QHP enrollment was backdated to December 1, 2017, and you testified that you paid your full premium for that month. However, the APTC that you began receiving on January 1, 2018 is based on calculations that did not go into effect until January 2018, so your eligibility for APTC in the month of December 2017 must be redetermined.

Therefore, NYSOH's November 5, 2017 eligibility determination and enrollment confirmation notices are **AFFIRMED**.

However, your case is sent back to NYSOH to determine your eligibility for financial assistance in the month of December 2017, based on a one-person household with an annual income of \$24,380.62 for 2017, residing in Rensselaer County.

NYSOH is directed to notify you in writing of your eligibility for financial assistance in the month of December 2017, and to apply any tax credit for which you are eligible to the December 2017 QHP premium that you paid, if you so choose.

PLEASE NOTE: Any APTC you receive for 2017 must be reconciled on your 2017 federal income tax return. Therefore, filing your income tax return before the resolution of this appeal is implemented could have consequences on any income tax liability or refund.

Decision

The November 5, 2017 eligibility determination and enrollment confirmation notices are **AFFIRMED**.

Your case is **RETURNED** to NYSOH to determine your eligibility for financial assistance in the month of December 2017, based on a one-person household with an annual income of \$24,380.62 for 2017, residing in Rensselaer County.

NYSOH is directed to notify you in writing of your eligibility for financial assistance in the month of December 2017, and to apply any tax credit for which you are eligible to the December 2017 premium that you paid, if you so choose.

Effective Date of this Decision: February 07, 2018

How this Decision Affects Your Eligibility

Your eligibility for your current APTC amount properly began on January 1, 2018.

However, your case is returned to NYSOH to determine your eligibility for financial assistance in December 2017, and to notify you in writing of this eligibility.

NYSOH is also directed to apply any tax credit for which you are eligible in December 2017 to the premium payment you made for that month, if you choose to do so.

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

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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 November 5, 2017 eligibility determination and enrollment confirmation notices are **AFFIRMED**.

Your case is **RETURNED** to NYSOH to determine your eligibility for financial assistance in the month of December 2017, based on a one-person household in Rensselaer County, with an annual income of \$24,380.62 for 2017.

NYSOH is directed to notify you in writing of your eligibility for financial assistance in the month of December 2017, and to apply any tax credit for which you are eligible to the December 2017 premium that you paid, if you so choose.

Your eligibility for your current APTC amount properly began on January 1, 2018.

However, your case is returned to NYSOH to determine your eligibility for financial assistance in December 2017, and to notify you in writing of this eligibility.

NYSOH is also directed to apply any tax credit for which you are eligible in December 2017 to the premium payment you made for that month, if you choose to do so.

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&etumi ama wo obi a okyerε 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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