



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

Notice of Decision

Decision Date: March 21, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027478

[REDACTED]

Dear [REDACTED],

On March 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 17, 2018 plan enrollment notice, and January 17, 2018 plan 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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NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000027478



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 and your spouse's enrollment in a qualified health plan with an advance premium tax credit (APTC) of \$479.00 per month and cost sharing reductions were effective January 1, 2018?

Did NYSOH properly determine that you and your spouse's enrollment in a qualified health plan with an APTC amount of \$769.35 per month and cost-sharing reductions were effective no earlier than February 1, 2018?

Procedural History

On October 31, 2017, NYSOH issued a renewal notice stating that you and your spouse were eligible for advance premium tax credit of \$769.35 per month and cost-sharing reductions, effective January 1, 2018.

On November 17, 2017, NYSOH issued a plan enrollment notice stating that you and your spouse were enrolled in a qualified health plan with an APTC of \$479.00 per month, effective January 1, 2018.

On January 17, 2018, NYSOH issued a plan enrollment notice stating that you and your spouse were enrolled in a qualified health plan with an APTC of \$769.35 per month, effective February 1, 2018.

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On January 19, 2018, you spoke to NYSOH's Account Review Unit and appealed the plan enrollment notices insofar as your and your spouse's eligibility for \$769.35 per month advance premium tax credit did not begin on January 1, 2018.

On March 12, 2018, 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) According to your NYSOH account and your testimony, you and your spouse were determined eligible for APTC in the amount of \$769.35 per month beginning January 1, 2018, but that when you and your spouse were enrolled into your qualified health plan on January 1, 2018, your monthly APTC was only \$479.00 per month.
- 2) According to Incident [REDACTED] in your NYSOH account and your testimony, you contacted NYSOH by telephone on December 15, 2017. During that call, you notified NYSOH that there was a discrepancy in the amount of APTC for which you and your spouse were eligible (\$769.35 per month), and the amount of APTC applied to your qualified health plan premiums (\$479.00 per month). NYSOH advised you that you and your spouse's correct APTC was \$769.35 per month, that the monthly APTC of \$479.00 was an error, and that NYSOH would correct it.
- 3) According to Incident [REDACTED] in your NYSOH account and your testimony, a NYSOH representative manually corrected this error on January 16, 2018, by making you and your spouse's monthly APTC amount of \$769.35 per month effective February 1, 2018.
- 4) You testified that you and your spouse are seeking to have the APTC amount of \$769.35 per month begin on January 1, 2018, because you paid your qualified health plan the higher premium amount for January 2018, and the plan stated they will only reimburse you if they start date of your \$769.35 monthly APTC is January 1, 2018.

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)). 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)).

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 under review is whether NYSOH properly determined that you and your spouse's enrollment in a qualified health plan with an APTC of \$479.00 per month and cost sharing reductions were effective January 1, 2018.

On October 31, 2018, NYSOH issued a renewal notice stating that you and your spouse were eligible for APTC in the amount of \$769.35 per month, beginning January 1, 2018. However, on November 17, 2018, NYSOH issued a plan enrollment notice stating that you and your spouse were eligible for APTC in the amount of \$479.00 per month.

Incident [REDACTED] in your NYSOH account, coupled with your credible testimony, reflect that NYSOH acknowledged that you and your spouse's correct

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monthly APTC amount was \$769.35, that the monthly APTC amount of \$479.00 was an error, and that NYSOH corrected that error on January 16, 2018.

Therefore, it is reasonable to conclude that the APTC amount of \$479.00 per month in the November 17, 2018 plan enrollment notice was an error and must be RESCINDED.

The second issue under review is whether NYSOH properly determined that you and your spouse's enrollment in a qualified health plan with an APTC amount of \$769.35 per month and cost-sharing reductions were effective no earlier than February 1, 2018.

On January 16, 2018, NYSOH updated the information in your NYSOH account and resolved the incident on file.

When an individual changes information in their application on or before the fifteenth of any month, NYSOH must make the redetermination that results from the change effective the first day of the following month. Information changed the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

Since NYSOH changed the information in your NYSOH account on January 16, 2018, ordinarily the effective date of the changes would be the first day of the second month following January 2018; that is as of March 1, 2018. The credible evidence of record reflects, however, that a NYSOH representative manually backdated the effective date of your enrollment in your qualified health plan with a \$769.35 monthly APTC from March 1, 2018, to February 1, 2018.

However, but for the error in your NYSOH account preventing your and your spouse's full monthly APTC from being applied as of January 1, 2018, your correct APTC amount of \$769.35 per month would have started January 1, 2018, not February 1, 2018.

Accordingly, the January 17, 2018 plan enrollment notice is MODIFIED to state that your and your spouse's enrollment in your qualified health plan with an APTC of \$769.35 per month is effective January 1, 2018.

Your case is RETURNED to NYSOH to effectuate these changes and notify you accordingly, and to Plan Management to ensure that the qualified health plan records reflect that you and your spouse are enrolled with an APTC amount of \$769.35 and that this amount is applied in full to your plan premium for the month of January 2018.

Decision

The November 17, 2017 plan enrollment notice is RESCINDED.

The January 17, 2018 plan enrollment notice is MODIFIED to state that your and your spouse's enrollment in your qualified health plan with an APTC of \$769.35 per month and with cost-sharing reductions is effective January 1, 2018.

Your case is RETURNED to NYSOH to effectuate these changes and notify you accordingly, and to Plan Management to ensure that the qualified health plan records reflect that you and your spouse are enrolled with an APTC amount of \$769.35 and that this amount is applied in full to your plan premium for the month of January 2018.

Effective Date of this Decision: March 21, 2018

How this Decision Affects Your Eligibility

An APTC of \$479.00 was applied to your January 2018 premium in error.

You and your spouse were eligible for an APTC in the full amount of \$769.35 for the month of January 2018.

Your case is being sent back to NYSOH to apply the full amount of monthly APTC to which you and your spouse are entitled (\$769.35) for the month of January 2018.

Your case is also being sent back to Plan Management to conduct outreach to your and your spouse's qualified health plan to ensure that the an APTC in the full amount of \$769.35 is applied to your monthly premium.

You will need to arrange with the health plan directly the credit or reimbursement of any over-payment made those months.

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.

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).

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 November 17, 2017 plan enrollment notice is RESCINDED.

The January 17, 2018 plan enrollment notice is MODIFIED to state that your and your spouse's enrollment in your qualified health plan with an APTC of \$769.35 per month and with cost-sharing reductions is effective January 1, 2018.

Your case is RETURNED to NYSOH to effectuate these changes and notify you accordingly, and to Plan Management to ensure that the qualified health plan records reflect that you and your spouse are enrolled with an APTC amount of \$769.35 and that this amount is applied in full to your plan premium for the month of January 2018.

An APTC of \$479.00 was applied to your January 2018 premium in error.

You and your spouse were eligible for an APTC in the full amount of \$769.35 for the month of January 2018.

Your case is being sent back to NYSOH to apply the full amount of monthly APTC to which you and your spouse are entitled (\$769.35) for the month of January 2018.

Your case is also being sent back to Plan Management to conduct outreach to your and your spouse's qualified health plan to ensure that the an APTC in the full amount of \$769.35 is applied to your monthly premium.

You will need to arrange with the health plan directly the credit or reimbursement of any over-payment made those months.

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 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 דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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