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

Notice of Decision

Decision Date: December 9, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000011823

[redacted]

Dear [redacted],

On December 2, 2016, you both appeared by telephone at a hearing on your appeal of NY State of Health's September 2, 2016 eligibility determination.

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 NY State of Health 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: December 9, 2016

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000011823

[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 you ([redacted] were ineligible for financial assistance effective October 1, 2016?

Procedural History

On September 1, 2016, NYSOH received your updated application for financial assistance. That day a preliminary eligibility determination was prepared with regard to the last application, stating you were ineligible for financial assistance effective October 1, 2016.

Also on September 1, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination as it related to the denial of financial assistance to help pay for your qualified health plan.

On September 2, 2016 NYSOH issued an eligibility determination notice based on the September 1, 2016 application stating that you were ineligible for financial assistance effective October 1, 2016 because your income was over the allowable limits. The determination stated you qualified to select a health plan outside of the open enrollment period for 2016. You were asked to confirm your selection of a health plan no later than October 30, 2016.

On November 22, 2016, 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 testified that you expect to file your 2016 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself ([redacted]

3) The application that was submitted on September 1, 2016, listed annual household income of $71,000.00, consisting of $51,000.00 you earn from your employment and $20,000.00 your spouse receives in Social Security Disability payments. You testified that this amount was correct.

4) You testified you currently receive in gross income a steady amount of $2,246.32 every two weeks.

5) You testified your spouse receives $1,500.00 a month every month in Social Security Disability payments.

6) Your application states that you will not be taking any deductions on your 2016 tax return. You testified this was correct.

7) You testified your spouse lost his employer sponsored insurance effective August 31, 2016.

8) You testified your spouse is currently covered under your employer sponsored insurance, but that it is too costly.

9) Your application states that you live in Suffolk County.

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

Applicable Law and Regulations

<u>Advance Payments of Premium Tax Credit</u>

Advance payments of the 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)).

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 $ 16,020.00 for a two-person household (81 Fed. Reg. 4036).

Legal Analysis

The issue under review is whether NYSOH properly determined that you ([redacted] were ineligible for financial assistance effective October 1, 2016.

The application that was submitted on August 26, 2016, listed an annual household income of $71,000.00 and the eligibility determination relied upon that information.

Advance payments of the premium tax credit (APTC) are generally available to a person who is eligible to enroll in a qualified health plan (QHP) and expects to have a household income between 138% and 400% of the applicable federal poverty level (FPL).

You are in a two-person household. You expect to file your 2016 income taxes as married filing jointly and will claim no dependents on that tax return.

An annual income of $71,000.00 is 443.2% of the 2016 FPL for a two-person household. At 443.2% of the FPL, you would be ineligible to receive advance premium tax credits or financial assistance with paying for a qualified health plan.

Since the September 2, 2016 eligibility determination properly stated that, based on the information you provided, were eligible to purchase a qualified health plan at full cost, and ineligible for financial assistance was correct and is AFFIRMED.

If you wish to be considered for a hardship exemption, which would exempt you from paying a penalty for not having health insurance during 2015, you can check the Federal Marketplace website (www.healthcare.gov) for an application.

Decision

The September 2, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: December 9, 2016

How this Decision Affects Your Eligibility

You ([redacted] remain eligible to purchase a qualified health plan at full cost effective October 1, 2016.

If You Disagree with this Decision (Appeal Rights)

This Decision is final unless you submit an appeal request to U.S. Department of Health and Human Services 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 U.S. Department of Health and Human Services. 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 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 September 2, 2016 eligibility determination notice is AFFIRMED.

You ([redacted] remain eligible to purchase a qualified health plan at full cost effective October 1, 2016.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

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