



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

## Notice of Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013282

[REDACTED]

Dear [REDACTED],

On February 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 3, 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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DEPARTMENT OF HEALTH  
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## Decision

Decision Date: April 21, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013282

[REDACTED]

## Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Was your appeal of the NY State of Health's (NYSOH) September 3, 2016 eligibility determination notice timely?

## Procedural History

On September 2, 2016, NYSOH received an updated application for financial assistance with health insurance for you and your spouse.

On September 3, 2016, NYSOH issued a notice of eligibility determination stating you and your spouse were eligible to receive up to \$459.00 in advance payments of the premium tax credit (APTC), effective October 1, 2016. That notice further stated you and your spouse were no longer eligible for cost-sharing reductions, because your household income of \$42,836.00 was over the allowable income limit of \$39,825.00.

On November 15, 2016, your spouse spoke to NYSOH's Account Review Unit and appealed this eligibility determination insofar as you and your spouse were not eligible for an increased level of financial assistance to lower your deductible.

On February 16, 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.

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## Findings of Fact

A review of the record supports the following findings of fact:

- 1) NYSOH received an updated application for financial assistance with health insurance for you and your spouse on September 2, 2016. This application indicated your child was no longer applying for insurance. Additionally, the application indicated you were no longer claiming your child as a dependent.
- 2) On September 3, 2016, NYSOH issued a notice of eligibility determination indicating the APTC you and your spouse were now eligible for was reduced to \$459.00 monthly and you no longer qualified for cost-sharing reductions.
- 3) Effective October 1, 2016, the individual annual deductible for the QHP you and your spouse were enrolled in increased from \$1,500.00 to \$2,000.00.
- 4) You testified you are seeking an increased level of financial assistance and a lower deductible.
- 5) A formal appeal was not filed in this matter until November 15, 2016.
- 6) There is no record of any activity on your account between the September 2, 2016 updated application and when your spouse contacted NYSOH on November 15, 2015 to appeal the September 3, 2016 eligibility determination.
- 7) Your account confirms you and your spouse enrolled in a QHP, effective January 1, 2017, with a \$600.00 annual individual deductible.

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

## Applicable Law and Regulations

### Valid Appeal Requests

An applicant has the right to appeal to NYSOH's Appeals Unit: (1) an eligibility determination, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (2) a redetermination of eligibility, including the amount of advance payments of the premium tax credit and level of cost-sharing reductions; (3) an eligibility determination for an exemption; (4) a failure by NYSOH to provide timely notice of an eligibility determination; and (5) a

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denial of a request for a special enrollment period (45 CFR § 155.505, 45 CFR § 155.505(b)(1)(iii), 45 CFR § 155.305(b), and 45 CFR § 155.420(d)).

Individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH (45 CFR § 155.520(b)(2); 18 NYCRR § 358-3.5(b)(1)).

## **Legal Analysis**

The only issue under review is whether your appeal of NYSOH's September 3, 2016 eligibility determination notice was timely.

On September 3, 2016, after you updated your NYSOH account, NYSOH issued an eligibility determination stating you and your spouse were eligible to receive up to \$459.00 in APTC, effective October 1, 2016. That notice further stated you and your spouse were no longer eligible for cost-sharing reductions, because your household income of \$42,836.00 was over the allowable income limit of \$39,825.00.

Your spouse contacted NYSOH on November 15, 2016 to appeal this eligibility determination insofar as you were not eligible for an increased level of financial assistance and a lower deductible.

Pursuant to the above cited regulations, individual applicants and enrollees must request a hearing within 60 days of the date of their notice of eligibility determination by NYSOH.

For an appeal to have been valid on the issue of the eligibility for financial assistance for you and your spouse, as indicated in the eligibility determination notice dated September 3, 2016, an appeal should have been filed by November 2, 2016. There is no evidence you or your spouse attempted to dispute this eligibility with NYSOH prior to November 15, 2016. Accordingly, the appeal in this matter is untimely as it was not filed within the 60-day period allowable under the applicable regulations.

As there has been no timely appeal of the September 3, 2016 eligibility determination, your appeal of this determination is **DISMISSED**.

It is noted that eligibility for financial assistance through NYSOH is based on income and household size. Household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year. Your account confirms that you updated your application on September 2, 2016 by indicating you were no longer claiming your child as a dependent. This reduced your household size, thus reducing the level of financial assistance to

which your household was eligible. As a result, you and your spouse no longer qualified for cost-sharing reductions you were previously receiving.

## **Decision**

Your appeal of the September 3, 2016 eligibility determination notice is untimely and is DISMISSED.

**Effective Date of this Decision:** April 21, 2017

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

This decision does not affect eligibility for you or your spouse.

## **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 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).

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**

Your appeal of the September 3, 2016 eligibility determination notice is untimely and is DISMISSED.

This decision does not affect eligibility for you or your spouse.

### **Legal Authority**

We are sending you this notice 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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