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

Notice of Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016353

[redacted]

Dear [redacted]

On June 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's December 30, 2016 eligibility determination notice, February 28, 2017 eligibility determination notice, and March 1, 2017 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 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
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: June 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016353

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Did NY State of Health properly determine that you were eligible to receive up to $306.00 per month in advance payments of the premium tax credit, effective February 1, 2017?

Did NY State of Health properly determine that you were ineligible for cost-sharing reductions, effective February 1, 2017?

Did NY State of Health properly determine that you were ineligible for the Essential Plan, effective February 1, 2017?

Did NY State of Health properly determine that you were eligible to receive up to $295.00 per month in advance payments of the premium tax credit, effective April 1, 2017?

Did NY State of Health properly determine that you were ineligible for cost-sharing reductions, effective April 1, 2017?

Did NY State of Health properly determine that you were ineligible for the Essential Plan, effective April 1, 2017?

Did NY State of Health properly determine that your enrollment in a qualified health plan and the application of advance payments of the premium tax credit were effective no earlier than April 1, 2017?

Procedural History

On December 12, 2016, you submitted an application for financial assistance.

On December 13, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan for a limited time, effective January 1, 2017. This notice directed you to submit proof of income by March 12, 2017 in order to confirm your eligibility.

Also on December 13, 2016, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in your Essential Plan, effective January 1, 2017.

On December 12, 2016, income documentation was uploaded to your NYSOH account.

On December 29, 2016, NYSOH recalculated your income based on this documentation, updated the income information in your application, and submitted an application on your behalf.

On December 30, 2016, NYSOH issued a notice of eligibility determination, based on the December 29, 2016 application, stating that you were eligible to receive up to $306.00 per month in advance payments of the premium tax credit (APTC), effective February 1, 2017. That notice also stated that you were not eligible for cost-sharing reductions or the Essential Plan because your income was over the allowable income limits for those programs. This notice directed you to select a plan for enrollment.

Also on December 30, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your Essential Plan would end on January 31, 2017 because you were no longer eligible to enroll in the Essential Plan. This notice also directed you to select a plan for enrollment.

On February 27, 2017, you updated your application for financial assistance.

On February 28, 2017, NYSOH issued a notice of eligibility determination, based on the February 27, 2017 application, stating that you were eligible to receive up to $295.00 per month in APTC, effective April 1, 2017. You selected a qualified health plan for enrollment that day.

Also on February 28, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were found ineligible for the Essential Plan and were without coverage for the months of February 2017 and March 2017.

On March 1, 2017, NYSOH issued a notice of enrollment confirmation, based on your February 28, 2017 plan selection, stating that you were enrolled in a qualified health plan effective April 1, 2017, and that your APTC would be applied to your monthly premium as of April 1, 2017.

On June 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for seven days, to allow you to submit supporting documents.

On June 15, 2017, the Appeals Unit received via fax employee earnings records from two of your employers. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. The record is now closed.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself.

3) The application that you submitted on December 12, 2016 listed annual household income of $18,804.50, consisting of $9,652.50 from [redacted], and $9,152.00 from [redacted]

4) You testified that during 2016 you had a third employer, but this employment ended on November 9, 2016.

5) On December 12, 2016, you uploaded an Unemployment Insurance Monetary Benefit Determination from the Department of Labor, which stated that your claim was effective December 5, 2016 and would end December 10, 2017 with a weekly benefit rate of $430.00.

6) On December 29, 2016, NYSOH updated the income in your application to be $29,984.50, consisting of $9,652.00 from [redacted], [redacted], $9,152.00 from [redacted], and $11,180.00 from Unemployment Insurance Benefits.

7) The application that you submitted on February 27, 2017 listed annual household income of $30,836.00, consisting of $10,500.00 from [redacted], $8,976.00 from [redacted], $10,500.00 from [redacted], and $860.00 from Unemployment Insurance Benefits.

8) You testified that you currently have three employers. You further testified that your annual expected income from [redacted] is currently $10,500.00 and your annual expected income from [redacted] is currently $10,296.00. You also testified that you earn $250.00 a day from the [redacted] and work approximately two days per month.

9) On June 15, 2017, you submitted an employee earnings record from [redacted], which indicates that you were paid on February 3, 2017 a gross amount of $824.34, on February 17, 2017 a gross amount of $264.99, on March 17, 2017 a gross amount of $256.41, and on March 31, 2017 a gross amount of $263.01.

10) Also on June 15, 2017, you submitted a payroll detail from [redacted], which indicates that you were paid on February 15, 2017 a gross amount of $237.50, on March 1, 2017 a gross amount of $863.50, on March 15, 2017 a gross amount of $506.00, on March 29, 2017 a gross amount of $375.65, on April 12, 2017 a gross amount of $573.65, and on April 26, 2017 a gross amount of $406.45.

11) You testified that you received 4 weeks of Unemployment Insurance Benefits in 2017, $215.00 on January 4, 2017, January 13, 2017, January 23, 2017, and January 25, 2017.

12) You testified that you may be taking a deduction for scrubs and continuing education credits on your 2017 tax return, but you are not sure.

13) Your application states, and you testified that you live in Onondaga County.

14) Your NYSOH account reflects that you receive all of your notices from NYSOH by electronic mail. You testified that you have never changed the preference of how you receive notices from NYSOH.

15) You testified that you did not receive any electronic alert regarding the December 30, 2016 eligibility determination or the December 30, 2016 disenrollment notices which directed you to select a health plan.

16) You testified that you did not know that you had been disenrolled from your Essential Plan until sometime in late February 2017 or early March 2017 when you went to pick up a prescription.

17) You testified that you are seeking the Essential Plan as well as to be enrolled in coverage for the months of February 2017 and March 2017.

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

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

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)).

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 Federal Register 4036).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% 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).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). 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).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/basic-health-program.html).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Verification of Eligibility for the Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

NYSOH must verify the eligibility of an applicant for the Essential Plan consistent with the standards set in 45 CFR § 155.315 and § 155.320 (New York's Basic Health Plan Blueprint, pgs. 16-17, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html; 42 CFR § 600.345(a)(2)).

An applicant is required to attest to their household's projected annual income. (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant in order to resolve the inconsistency (45 CFR §155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any updates in eligibility to the Essential Plan effective the first day of the following month for changes received by NYSOH from the first to the fifteenth of any month (45 CFR § 155.420(b)(1)(i); *see also* 42 CFR § 600.320(c)). For updates 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 § 155.420(b)(1)(ii); *see also* 42 CFR § 600.320(c)).

APTC Effective Date

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective as of the first day of the month following the date of the notice (45 § 155.310(f), 45 CFR § 155.330(e), (f)(1)(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)).

Electronic Notices

Applicants may choose to receive notices and information from NYSOH either by electronic alerts or by regular mail. If the applicant elects to receive electronic notices, NYSOH must send an email or other electronic communication alerting the individual that a notice has been posted to the applicant's account (42 CFR § 600.330(e); 42 CFR § 435.918(b)(4)).

Additionally, if an electronic alert regarding a notice in an individual's NYSOH account fails, NYSOH must send out the notice by regular mail within three days of the failed alert (42 CFR § 435.918(b)(5)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible to receive up to $306.00 per month in advance payments of the premium tax credit, effective February 1, 2017.

On December 29, 2016, NYSOH recalculated your expected annual household income to be $29,984.50.

This was based on $9652.00 from [redacted] and $9,152.00 from [redacted] which amounts were reported by you, as well as $11,180.00 in Unemployment Insurance Benefits. The documentation you submitted from the Department of Labor indicates that your Unemployment Insurance Benefit was to be $430.00 per week, and NYSOH relied on this information to calculate your annual expected income. As NYSOH properly relied upon the information you submitted in determining your annual expected income, there is no calculation error, and the annual expected household income of $29,984.50 relied upon in the December 30, 2016 eligibility determination will not be modified.

You expect to file your 2017 tax return as single and will claim no dependents on that tax return, therefore, you are in a one-person household.

You reside in Onondaga County, where the second lowest cost silver plan available for an individual through NYSOH costs $513.26 per month.

An annual income of $29,984.50 is 252.39% of the 2016 FPL for a one-person household. At 252.39% of the FPL, the expected contribution to the cost of the health insurance premium is 8.28% of income, or $206.92 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county ($513.26 per month) minus your expected contribution ($206.92 per month), which equals $306.34 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $306.00 per month in APTC.

The second issue is whether NYSOH properly determined that you were ineligible for cost-sharing reductions, effective February 1, 2017.

Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of $29,984.50 is 252.39% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan, effective February 1, 2017.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person

household. Since an annual household income of $29,984.50 is 252.39% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the December 30, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $306.00 per month in APTC, ineligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

The fourth issue is whether NYSOH properly determined that you were eligible to receive up to $295.00 per month in advance payments of the premium tax credit, effective April 1, 2017.

The application that was submitted on February 27, 2017 listed an annual household income of $30,836.00 and the eligibility determination relied upon that information.

An annual income of $30,836.00 is 259.56% of the 2016 FPL for a one-person household. At 259.56% of the FPL, the expected contribution to the cost of the health insurance premium is 8.49% of income, or $218.24 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county ($513.26 per month) minus your expected contribution ($218.24 per month), which equals $295.02 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $295.00 per month in APTC.

The fifth issue is whether NYSOH properly determined that you were ineligible for cost-sharing reductions, effective April 1, 2017.

Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of $30,836.00 is 259.56% of the applicable FPL, NYSOH correctly found you to be ineligible for cost sharing reductions.

The sixth issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan, effective April 1, 2017.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since an annual household income of $30,836.00 is 259.56% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the February 28, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $295.00 per month in APTC, ineligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is correct.

However, any changes in APTC must be made effective as of the first day of the month following the date of the notice.

Therefore, the February 28, 2017 eligibility determination is MODIFIED to state that you were eligible for up to $295.00 per month in APTC, effective March 1, 2017.

The seventh issue under review is whether NYSOH properly determined that your enrollment in a qualified health plan and the applicability of your APTC were effective April 1, 2017.

On December 30, 2016, NYSOH issue a notice of eligibility stating that you were eligible for APTC, and directing you to select a plan for enrollment. Also on December 30, 2016, NYSOH issue a disenrollment notice advising you that your enrollment in your Essential Plan would end on January 31, 2017 and that you would need to select a plan.

However, the record reflects that you elected to receive alerts regarding notices from NYSOH electronically. You credibly testified that you did not receive an electronic alert regarding the December 30, 2016 eligibility determination or disenrollment notice, which directed you to select a plan for enrollment. There is no evidence in your account documenting any email alert was sent to you regarding these notices or the need to select a plan for enrollment.

Therefore, it is concluded that NYSOH did not give you proper notice of your eligibility redetermination or the need to select a plan for enrollment.

The date on which a qualified health plan can take effect depends on the day a person selects the plan for enrollment. A plan that is selected from the date on which a qualified health plan can take effect depends on the day a person selects the plan for enrollment. A plan that is after the fifteenth day of a month goes into effect on the first day of the second following month.

Had you been properly notified of the eligibility redetermination, you would have been able to select a qualified health plan for enrollment as early as December 30, 2016.

Therefore, NYSOH's March 1, 2017 enrollment confirmation notice is MODIFIED to state that your enrollment in your qualified health plan as well as the application of your APTC were effective as of February 1, 2017.

During the hearing, you testified that the income information in your February 27, 2017 application is different from your current annual expected household income. You provided documentation from your employer [redacted], [redacted], which yields an annual expected income of $8,365.50 (gross amount of $1,608.75 for 10 weeks yields an annual weekly income of $160.88 per week, multiplied by 52 weeks. You provided documentation from your employer [redacted] which yields an annual expected income of $12,839.02 (gross amount of $2,962.85 for 12 weeks yields an annual weekly income of $246.90, multiplied by 52 weeks). You testified that your annual expected income from [redacted] is $6,000. This yields an annual expected household income of $27,204.02.

Therefore, your case is RETURNED to NYSOH to recalculate your eligibility based on a household of one residing in Onondaga County with an annual expected income of $27,204.02.

Decision

The December 30, 2016 eligibility determination notice is AFFIRMED.

The February 28, 2017 eligibility determination notice is AFFIRMED insofar as it found you eligible for up to $295.00 per month in APTC and MODIFIED to reflect that this APTC is effective as of March 1, 2017.

The March 1, 2017 enrollment confirmation notice is MODIFIED to reflect that your enrollment in a qualified health plan as well as the applicability of your APTC is effective February 1, 2017.

Your case is RETURNED to NYSOH to enroll you in your qualified health plan as of February 1, 2017, to apply your APTC of $306.00 from February 1, 2017 through February 28, 2017, to apply your APTC of $295.00 as of March 1, 2017, and to recalculate your eligibility based on a household of one residing in Onondaga County with an annual expected income of $27,204.02.

Effective Date of this Decision: June 28, 2017

How this Decision Affects Your Eligibility

You are eligible for up to $306.00 per month in APTC from February 1, 2017 through February 28, 2017.

You are eligible for up to $295.00 per month in APTC, effective March 1, 2017.

Your case is being sent back to NYSOH to enroll you in your qualified health plan as of February 1, 2017.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

Your case is being sent back to NYSOH to recalculate your eligibility based on the income information you provided during your hearing.

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 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 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 December 30, 2016 eligibility determination notice is AFFIRMED.

You are eligible for up to $306.00 per month in APTC from February 1, 2017 through February 28, 2017.

The February 28, 2017 eligibility determination notice is AFFIRMED insofar as it found you eligible for up to $295.00 per month in APTC and MODIFIED to reflect that this APTC is effective as of March 1, 2017.

You are eligible for up to $295.00 per month in APTC, effective March 1, 2017.

The March 1, 2017 enrollment confirmation notice is MODIFIED to reflect that your enrollment in a qualified health plan as well as the applicability of your APTC is effective February 1, 2017.

You are ineligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

Your case is RETURNED to NYSOH to enroll you in your qualified health plan as of February 1, 2017, to apply your APTC of $306.00 from February 1, 2017 through February 28, 2017, to apply your APTC of $295.00 as of March 1, 2017, and to recalculate your eligibility based on a household of one residing in Onondaga County with an annual expected income of $27,204.02.

Your case is being sent back to NYSOH to enroll you in your qualified health plan as of February 1, 2017 and to recalculate your eligibility based on the income information you provided during your hearing.

Legal Authority

We are sending you this notice 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:

[redacted]

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.

□□□□□ (Bengali)

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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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 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 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)

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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.

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).