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

Notice of Decision

Decision Date: June 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016870

[redacted]

Dear [redacted],

On June 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 22, 2017 eligibility determination 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 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016870

[redacted]

Issue

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

> Did New York State of Health (NYSOH) properly determine that you do not qualify to enroll in a qualified health plan outside of the open enrollment period, effective May 1, 2017?

Procedural History

According to your NYSOH account, you were enrolled in a bronze-level qualified health plan (QHP), effective February 1, 2017, with a premium of $222.32 after the monthly advance payment of the premium tax credit (APTC) of $191.00 was applied.

On March 16, 2017, NYSOH received your updated application for financial assistance. That day, a preliminary eligibility determination was prepared finding you eligible for tax credits and ineligible for cost-sharing reductions. You also attempted to enroll into a QHP but were unable to select a plan for enrollment

Also on March 16, 2017, you spoke to NYSOH's Account Review Unit and appealed your inability to enroll into a different qualified health plan outside of the open enrollment period.

On March 22, 2017, NYSOH issued an eligibility determination notice, based on your March 16, 2017 application, stating that you were eligible for up to $191.00 per month in APTC and ineligible for cost sharing reductions, effective May 1,

2017. That notice further stated the you were not eligible to enroll in a qualified health plan outside of the open enrollment period.

On June 21, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open to July 6, 2017, to allow you to submit supporting documents.

On June 24, 2017, you submitted four current consecutive weekly paystubs dated June 2, 2017 through June 23, 2017. This documentation was made part of the record as "Appellant's Exhibit A" and the record closed that day.

Findings of Fact

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

1) According to your NYSOH account, you have been enrolled in a qualified health plan through NYSOH since February 1, 2017.

2) On March 16, 2017, you applied for health insurance through NYSOH. You attempted to enroll in a different health plan that day.

3) You testified that you want to change your insurance coverage because you have an [redacted] that your current bronze-level health plan does not sufficiently cover.

4) The applications that were submitted on January 9, 2017 and March 16, 2017 listed annual household income of $34,164.00 in earnings from your employment. You testified that your income is higher and that you earn approximately $840.00 per week.

5) According to your NYSOH account, you plan on filing your 2017 taxes with a tax filing status of single and will claim no dependents on that tax return.

6) On June 24, 2017, you submitted four current consecutive weekly paystubs dated June 2, 2017 through June 23, 2017. The documents show that as of June 23, 2017, you received $23,222.85 in earned income year-to-date, which when divided by 25 pay periods equals an average weekly pay of $928.91 and an estimated 2017 annual gross income of $48,303.53 (*see* Appellant's Exhibit A).

7) Your application states that you live in Bronx County, New York.

8) You testified that since updating your application on March 16, 2017, there have been no other major changes to your household.

9) You testified that when NYSOH placed you into the bronze-level QHP on January 9, 2017, you relied on statements from the NYSOH representative that this plan covered a multitude of services free of charge. You further testified that, upon trying to use the insurance, you found out that the bronze-level plan did not cover anything.

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

Applicable Law and Regulations

Enrollment in a Qualified Health Plan

NY State of Health (NYSOH) must provide annual open enrollment periods during which time qualified individuals may enroll in a qualified health plan (QHP) and enrollees may change QHPs (45 CFR § 155.410(a)(1)).

For the benefit year beginning on January 1, 2016, the annual open enrollment period began on November 1, 2015, and extended through January 31, 2016 (45 CFR § 155.410(e)(2)).

Special Enrollment Periods

After each open enrollment period ends, NYSOH provides special enrollment periods to qualified individuals. During a special enrollment period, a qualified individual may enroll in a QHP, and an enrollee may change their enrollment to another plan. This is generally permitted when a triggering event occurs, such as:

(6) The enrollee or enrollee's dependent is newly eligible or ineligible for advance payments of the premium tax credit, or has a change in eligibility for cost-sharing reductions…

(45 CFR § 155.420(d)).

Generally, if a triggering life event occurs, the qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP (45 CFR § 155.420(c)(1)).

(45 CFR § 155.420(e)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you do not qualify to enroll in a qualified health plan outside of the open enrollment period, effective May 1, 2017.

NYSOH provided an open enrollment period from November 1, 2016 until January 31, 2017. The record reflects that you were enrolled in a bronze-level qualified health plan as of February 1, 2017. On March 16, 2017, you re-applied for health insurance and requested to enroll in a different qualified health plan. On March 17, 2017, NYSOH issued a notice stating in relevant part that you do not qualify to enroll in a qualified health plan outside of the open enrollment period.

Once the annual open enrollment period ends, a health plan enrollee must qualify for a special enrollment period to enroll in, or change to another health plan offered in NYSOH. In order to qualify for a special enrollment period, a person must experience a triggering event.

You testified that your income is higher than what is listed on the application dated March 16, 2017.

Generally, when an enrollee or enrollee's dependent is newly eligible or ineligible for advance payments of the premium tax credit, or has a change in eligibility for cost-sharing reductions, that is considered a triggering life event.

However, the applications that were submitted on January 9, 2017 and March 16, 2017 both listed annual household income of $34,164.00 in earned income. Therefore, based on the information you provided in those applications, your eligibility did not change.

Since, based on the information you provided, your eligibility for APTC and cost-sharing reductions did not change, NYSOH properly denied your request to enroll in different health plan as of March 16, 2017.

Therefore, NYSOH's March 22, 2017 eligibility determination that you do not qualify to select a health plan outside of the open enrollment period for 2017 is correct and must be AFFIRMED.

However, you testified, and submitted documentation to show, that the listed income amount was incorrect and that your gross income is substantially higher than what you reported on your application. The documentation you submitted on June 24, 2017 shows that as of June 23, 2017, you received $23,222.85 in earned income, which equals an estimated 2017 annual income of $48,303.53.

Since the record now contains a more accurate representation of your 2017 expected gross annual household income of $48,303.53, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a gross annual household income of $48,303.53 and a household size of one, for an individual residing in Bronx County.

Finally, a person who elects to take the APTC to help pay for the cost of an insurance premium must file a tax return to reconcile any differences between the amount of income the person reported to NYSOH and their actual gross income for that year, which may also result in a tax credit or reduction in tax liability if the full amount of APTC to which a person is entitled is not taken throughout the year. Conversely, if a person received more APTC than their maximum entitlement, based on gross income, they might owe the excess as an additional income tax liability. The amount of APTC to which you were entitled can be reconciled at the time you file your 2017 federal tax return.

Decision

The March 22, 2017 denial of a special enrollment period is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a gross annual household income of $48,303.53 and a household size of one, for an individual residing in Bronx County.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

Effective Date of this Decision: June 30, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. While your eligibility for financial assistance was based on your attestation of income and, therefore, was correct as of your March 16, 2017 application, your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2017 based on an annual household income of $48,303.53 per year and a household size of one, for an individual residing in Bronx County.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

The amount of APTC that you received, if incorrect, can be reconciled when you file your federal income tax return for 2017.

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 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

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- By fax: 1-855-900-5557

Summary

The March 22, 2017 denial of a special enrollment period is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance in 2017 based on a gross annual household income of $48,303.53 and a household size of one, for an individual residing in Bronx County.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

This is not a final determination of your eligibility. While your eligibility for financial assistance was based on your attestation of income and, therefore, was correct as of your March 16, 2017 application, your case is being sent back to NYSOH to redetermine your eligibility for financial assistance in 2017 based on an annual household income of $48,303.53 per year and a household size of one, for an individual residing in Bronx County.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

The amount of APTC that you received, if incorrect, can be reconciled when you file your federal income tax return for 2017.

Legal Authority

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

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.

□□□ (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)

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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.

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।

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.

(Urdu)اردو

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۔

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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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