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

Notice of Decision

Decision Date: July 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016886

[redacted]

Dear [redacted]

On June 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 10, 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).

This page intentionally left blank.

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).

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

Decision

Decision Date: July 28, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016886

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine you and your spouse were eligible for a qualified health plan, and no longer eligible for advance premium tax credits (APTC), effective April 1, 2017?
>
> Did NYSOH properly determine your deductible for your Bronze level qualified health plan was $8,000.00 per group effective March 1, 2017?

Procedural History

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

On December 13, 2016, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to receive up to $540.00 in APTC, effective January 1, 2017. The income listed in your application was $52,051.00.

On December 28, 2016, an enrollment notice was issued confirming your and your spouse's enrollment in a Healthfirst silver level qualified health plan with a premium responsibility of $367.13 per month with an annual deductible of $2,000.00 per person/$4,000.00 per group, effective February 1, 2017.

On January 31, 2017, you and your spouse asked NYSOH to end your coverage in your Healthfirst silver level qualified health plan. That same day, you and your spouse enrolled in a Fidelis Care bronze level qualified health plan with an effective date of March 1, 2017.

On February 1, 2017, a cancellation notice was issued confirming your and your spouse's Healthfirst silver level qualified health plan would end February 28, 2017.

Also on February 1, 2017, an enrollment notice was issued confirming your and your spouse's enrollment in a Fidelis Care bronze plan with a premium responsibility of $177.41 per month and an annual deductible of $4,000.00 per person or $8,000.00 per group effective March 1, 2017.

On March 9, 2017, NYSOH updated your application, in particular the income information was updated, and redetermined your and your spouse's eligibility for financial assistance.

On March 10, 2017, an eligibility determination notice was issued stating that you and your spouse were newly eligible to purchase a qualified health plan at full cost effective April 1, 2017. The notice stated the income listed in your application was $83,225.00.

On March 10, 2017, NYSOH issued an enrollment notice confirming your and your spouse's enrollment in a bronze level qualified health plan with a premium responsibility of $717.41 per month and an annual deductible of $8,000.00 per group effective March 1, 2017.

On March 16, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your APTC for the month of April 2017, and requested to be reenrolled in the silver level qualified health plan with Healthfirst.

On June 27, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, you testified you are no longer seeking enrollment through NYSOH and were only seeking the level of deductible and loss of APTC for the month of March and April, 2017 for the bronze level health plan you and your spouse were enrolled in. The record was developed during the hearing and closed at the end of the proceeding.

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 married filing jointly. You will claim one dependent on that tax return.

2) You are seeking APTC to be applied to your health plan for the month of April, 2017.

3) You are appealing the deductible amount you were provided for the month of March and April, 2017.

4) On December 12, 2016, an application was submitted which listed an annual household income of $52,051.00, consisting of income you earn from your employer in the amount of $34,371.00 annually, and from your spouse's employer [redacted] which was $340.00 weekly. You testified this was correct at the time.

5) On February 1, 2017, you faxed copies of your paystubs from [redacted] and your spouse's paystubs from [redacted] There were no paystubs or letter of separation provided from [redacted].

6) On March 9, 2017. income in your application was updated by an NYSOH representative based on the documentation received on February 1, 2017. A note associated with that update stated that new income was entered into your account from your spouse's job from [redacted].

7) The March 9, 2017, application listed an annual expected household income of $83,225.00, consisting of income you earn from your employer in the amount of $34,371.00 annually, and from your spouse's employer [redacted] which was $340.00 weekly and [redacted] for $31,174.00 a year.

8) You testified the annual income of $83,225.00 was incorrect, that your annual expected household income for 2017 from your employer would be $23,500.00, and your spouse's expected income would be $22,500.00.

9) On May 4, 2017, an application was submitted which listed an annual household income of $61,431.50 consisting of $30,117.75 annually from your employer, and $31,313.75 annually from your spouse's employer [redacted]

10) You testified you incurred medical bills in the month of April, 2017 of approximately $6,500.00 because you had not met the deductible of your bronze level plan.

11) Your application states that you live in [redacted]

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)).

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 $20,160.00 for a three-person household (81 Federal Register 4036).

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).

Redetermination During a Benefit Year

When a redetermination is issued as a result of a change in an applicant's information, NYSOH must generally make that redetermination effective on the first day of the month following the date NYSOH is notified of the change (45 CFR § 155.330 (f)(1)(ii)). However, NYSOH may determine that its policy will be that any change made after the 15th of any month will not be effective until the first of the second following month (45 CFR § 155.330(f)(2)).

When an eligibility redetermination results in a change in the amount of advance payments of the premium tax credit (APTC) for the benefit year, NYSOH must recalculate the amount of APTC in such a manner as to account for any advance payments already made on behalf of the tax filer, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for that benefit year (45 CFR § 155.330(g)).

Valid Appeal Requests

An applicant has the right to appeal: (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 the Exchange to provide timely notice of an eligibility determination and (5) a denial of a request to vacate dismissal made by the NY State of Health Appeals Unit (45 CFR § 155.505).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your spouse were eligible to purchase a qualified health plan at full cost, and no longer eligible for APTC, effective April 1, 2017.

On December 12, 2016, an application was submitted listing an annual household income of $52,051.00, consisting of income you earn from your employer, [redacted], in the amount of $34,371.00 annually, and from your spouse's employer [redacted] which was $340.00 weekly. Based on this application, you and your spouse were found eligible to receive $540.00 in APTC per month.

On February 1, 2017, you faxed copies of your paystubs from [redacted] and paystubs for your spouse's employer [redacted] There were no paystubs or letter of separation provided from your spouse's employer that was listed on your NYSOH application, [redacted]

In response to the paystubs, your application was updated on March 9, 2017 by an NYSOH representative to reflect an annual household income of $83,225.00, consisting of income you earn from your employer in the amount of $34,371.00 annually, and from your spouse's employer [redacted] which was $340.00 weekly and [redacted] for $31,174.00 a year.

APTC is available for individuals whose annual household income is below 400% of the applicable federal poverty level (FPL).

You and your spouse are in a three-person household. You expect to file your 2017 income taxes as married filing jointly and will claim one dependent on that tax return.

An annual income of $83,225.00 is 412.82% of the 2016 FPL for a three-person household. Therefore, based on the information in the application at the time of the March 9, 2017 application, you and your spouse were no longer eligible to receive APTC because your income was over the applicable income limit for that program.

During the hearing, you testified the annual income of $83,225.00 listed in the March 9, 2017 application was incorrect. You testified that your annual expected household income for 2017 from your employer would be $23,500.00, and your spouse's expected income would be $22,500.00. However, there is no support in the record to find this testimony credible.

Since you submitted documentation that your spouse was employed at [redacted] and because there is no documentation or testimony to support that your spouse was no longer employed by [redacted] in 2017, NYSOH was correct in including both incomes in the March 9, 2017 application.

Therefore, the March 10, 2017, eligibility determination notice finding you and your spouse eligible for a full price qualified health plan and ineligible for APTC as of April 1, 2017, is AFFIRMED.

The second issue is whether NYSOH properly determined your deductible for your bronze level qualified health plan was $8,000.00 per group effective March 1, 2017.

On January 31, 2017, you and your spouse enrolled in a Fidelis Care Bronze level qualified health plan with an effective date of March 1, 2017.

An enrollment notice was issued on February 1, 2017, confirming your and your spouse's enrollment in a bronze plan with a premium responsibility of $177.41 per month and an annual deductible of $4,000.00 per person or $8,000.00 per group effective March 1, 2017.

During your hearing, you testified you incurred medical bills in the month of April, 2017 of approximately $6,500.00 because you had not met the deductible of your bronze level plan.

The level of an individual's deductible is set by metal level by NYSOH and contracting health plans. The plan you selected in the bronze metal level had a required annual deductible of up to $8,000.00 per year.

The particulars of the terms of coverage regarding covered medical services, treatment, prescriptions, and the amount of co-pays, deductibles, and out of pockets costs for which you are responsible for are set by the individual plans and are not based on an eligibility determination made by NYSOH. Therefore, your issue is not something that the New York State of Health Appeals Unit can review and we must DISMISS your appeal on this issue.

Decision

The March 10, 2017, eligibility determination notice is AFFIRMED.

Your appeal of the level of your annual deductible for your bronze level qualified health plan is DISMISSED.

Effective Date of this Decision: July 28, 2017

How this Decision Affects Your Eligibility

You and your spouse were eligible to enroll in a full price qualified health plan as of April 1, 2017.

You and your spouse were not eligible for ATPC as of April 1, 2017.

This decision has no effect on any subsequent determinations made by NYSOH.

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 withi.n 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

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).

- 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

Summary

The March 10, 2017, eligibility determination notice is AFFIRMED.

You and your spouse were eligible to enroll in a full price qualified health plan as of April 1, 2017.

You and your spouse were not eligible for ATPC as of April 1, 2017.

Your appeal of the level of your annual deductible for your bronze level qualified health plan is DISMISSED.

This decision has no effect on any subsequent determinations made by NYSOH.

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.

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).

□□□ □□ □□□□□□□□□□□□□ □□□□ □□□ □□□□□ □□□□□ □□□ □□□□□□□□□□ □□□□□□□□□ □□ □□□□□,
□□□□□□□□ □□□ 1-855-355-5777 □□□□□□ □□ □□□□□ □□□□ □□ □□□□□□ □□□ □□□□ □□□□□□□□□□ □□□□
□□□□□□ □□□□ □□□□□□ □□□□ □□□□□

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)

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).

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).