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

Notice of Decision

Decision Date: March 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025045

[redacted]

Dear [redacted],

On February 5, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 30, 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: March 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025045

[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 and your spouse were eligible to enroll in a qualified health plan only at full cost, effective January 1, 2018?

Procedural History

On November 29, 2017, you submitted an updated application for health insurance and financial assistance through NYSOH for you and your spouse. That day, a preliminary eligibility determination was prepared stating that you and your spouse were eligible to purchase a qualified health plan (QHP) at full cost, effective January 1, 2018.

Also on November 29, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination insofar as you and your spouse were found not eligible for any amount of financial assistance.

On November 30, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to purchase a QHP at full cost, effective January 1, 2018. That notice also stated that you and your spouse were not eligible for an advance premium tax credit (APTC) and cost-sharing reductions (CSR) because your annual household income was over the allowable income limits for those programs.

On December 12, 2017, NYSOH issued a notice stating that you and your spouse were eligible for APTC for a limited time, effective January 1, 2018. This was because you had been granted Aid to Continue pending the outcome of your appeal.

Also on December 12, 2017, NYSOH issued an enrollment notice confirming that you and your spouse had been enrolled in a bronze-level QHP with a monthly premium of $289.99 per month after the application of $542.00 of APTC, with plan enrollment start date of January 1, 2018.

On February 5, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Spanish interpreter # [redacted] provided interpreter services. The record was developed during the hearing and held open until February 16, 2018 to allow you time to submit supporting documents.

On February 14, 2018, NYSOH received your supporting documents by upload to your account. The documents were incorporated into the record as Appellant's Exhibit #1 and the record was closed.

Findings of Fact

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

1) You testified that you expect to file your tax return for 2018 with a tax filing status of married filing jointly. You will claim no dependents on that tax return.

2) You are seeking insurance for you and your spouse.

3) The application that was submitted on November 29, 2017 listed annual household income of $74,400.00, consisting of $67,200.00 you earn from your employment and $7,200.00 your spouse receives in wages. You testified that at the time this amount was correct.

4) You testified that you work for [redacted]., earn $35/hour and work 40 hours a week. You testified that you are paid $1,400.00 weekly.

5) You testified that your spouse no longer works for [redacted] and her last date of employment was December 29, 2017.

6) On February 14, 2017 you submitted four weekly earnings statements as follows: pay date January 12, 2018 with gross pay of $1,400.00, pay date January 19, with gross pay of $1,400.00, pay date January 26, 2018 with pay date $1,400.00 and pay date February 2, 2018 with gross pay of

$1,400.00. You also submitted a letter from [redacted] stating your spouse's last day of employment with [redacted] was December 29, 2017.

7) Your November 29, 2017 application states that you will not be taking any deductions on your 2018 tax return.

8) According to your NYSOH account and your testimony you and your spouse live in Westchester County.

9) You testified that you received APTC last year and that you would like to continue to receive APTC so you can afford health insurance.

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

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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 2017 FPL, which is $16,240.00 for a two-person household (82 Federal Register 8831).

Cost-Sharing Reductions

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a qualified health plan 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 qualified health plan (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you and your spouse were eligible to enroll in a qualified health plan at full cost, effective January 1, 2018.

The application that was submitted on November 29, 2017 listed an annual household income of $74,400.00, consisting of $67,200.00 you earn from your employment and $7,200.00 your spouse receives in wages. The eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2018 income tax return as married filing jointly and will claim no dependents on that tax return.

APTC is available to a person who has a household income effectively greater than 138% and no greater than 400% of the applicable FPL. Since a household income of $74,400.00 is 458.12% of the 2017, the November 30, 2017 eligibility determination notice issued by NYSOH correctly found you and your spouse not eligible for APTC.

CSR is available to a person who has a household income no greater than 250% of the FPL and is eligible for APTC. Since you and your spouse were found not eligible for APTC, NYSOH correctly found you and your spouse not eligible for CSR.

Since the November 30, 2017 eligibility determination notice properly stated that, based on the information you provided, you and your spouse were eligible to enroll in a QHP at full cost, not eligible for APTC, and not eligible for CSR, it is correct and is AFFIRMED.

At the hearing, you testified that the income information in the November 29, 2017 application is now incorrect. You testified and supplied documentation that your spouse no longer works for [redacted] and therefore will have no earnings in 2018. You testified and supplied earning statements that show that you earn $35 per hour and work a 40-hour week. Your four earning statements that you submitted show that you are paid weekly a gross amount of $1,400.00. Therefore, based on the record as developed at the hearing and documents you submitted, your expected household income for 2018 is $72,800.00 ($1,400.00/week X 52 weeks).

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of February 5, 2018, using a two-person household for a family residing in Westchester County, with expected 2018 annual income of $72,800.00, and to notify you accordingly.

Decision

The November 30, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of February 5, 2018, using a two-person household for a family residing in Westchester County, with expected 2018 annual income of $72,800.00, and to notify you accordingly.

Effective Date of this Decision: March 9, 2018

How this Decision Affects Your Eligibility

You and your spouse were eligible to purchase a QHP at full cost, effective January 1, 2018.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of February 5, 2018, using a two-person household for a family residing in Westchester County, with expected 2018 annual income of $72,800.00, and to notify you accordingly.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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

- By fax: 1-855-900-5557

Summary

The November 30, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of February 5, 2018, using a two-person household for a family residing in Westchester County, with expected 2018 annual income of $72,800.00, and to notify you accordingly.

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).

You and your spouse were eligible to purchase a QHP at full cost, effective January 1, 2018.

Your case is RETURNED to NYSOH to redetermine your family's eligibility for financial assistance as of February 5, 2018, using a two-person household for a family residing in Westchester County, with expected 2018 annual income of $72,800.00, and to notify you accordingly.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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.

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।

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).

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 नि:शुल्क 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)

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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