



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

Notice of Decision

Decision Date: August 1, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017323

[REDACTED]

Dear [REDACTED]

On July 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 28, 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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DEPARTMENT OF HEALTH
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Decision Date: August 1, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017323

[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, your spouse, and your oldest child were eligible to enroll in the Essential Plan, effective May 1, 2017, and no longer eligible to receive advance payments of the premium tax credit (APTC) or to remain enrolled in a qualified health plan?

Procedural History

On February 4, 2017, NYSOH issued an eligibility determination stating in part that you, your spouse, and your oldest child (child) were eligible to share in \$1,025.00 per month in APTC for a limited time, effective March 1, 2017. The notice also instructed you, your spouse, and your child to submit documentary proof of income by February 27, 2017 and informed you that, if you miss this due date, you might lose your insurance or receive less help paying for your coverage.

Also on February 4, 2017, NYSOH issued a plan enrollment notice confirming in part that you, your spouse, and your child were enrolled in a family platinum-level qualified health plan, effective January 1, 2017, with APTC to be applied as of that date.

On February 22, 2017, NYSOH issued an eligibility determination notice stating in part that you, your spouse, and your child were eligible to purchase a qualified health plan at full cost, effective April 1, 2017, because your household income

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was over the allowable income limits for any of the insurance affordability programs offered through NYSOH.

Also on February 22, 2017, NYSOH issued a plan enrollment notice confirming in part that you, your spouse, and your child were enrolled in a platinum-level QHP at full cost.

On March 9, 2017, NYSOH issued a disenrollment notice stating in part that your family's platinum-level QHP coverage would end March 31, 2017, because your family was no longer eligible to enroll in a full cost QHP.

On March 28 and 29, 2017, NYSOH issued eligibility determination notices stating in part that you, your spouse, and your child were eligible to enroll in the Essential Plan for a limited time and with a \$20.00 monthly premium each, effective May 1, 2017. The notices instructed you to submit documentary proof of income for you, your spouse, and your child by June 25, 2017. The notices also stated that you all needed to pick a plan.

On March 28, 2017, NYSOH issued an appeal acknowledgement notice of your March 27, 2017 request to have the eligibility redetermination reviewed for you, your spouse, and your child insofar as you all were no longer eligible to receive APTC or remain enrolled in a QHP.

On April 13, 2017, NYSOH issued an eligibility determination notice stating that you, your spouse, and your child were eligible to share in APTC for a limited time as of April 1, 2017. This was because you all had been granted Aid to Continue until a decision is to be made on your appeal.

On July 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

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 two dependents on that tax return.
- 2) You are seeking financial assistance with insurance for yourself, your spouse and your one child.
- 3) You testified that the Essential Plan does not work for your family because of the treatment plans offered and your spouse's need for continued specialized care.

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- 4) You testified that, in April 2017, you paid the full premium for coverage in your family's platinum-level QHP that month.
- 5) You submitted to NYSOH your 2016 Form 1040, US Individual Income Tax Return, which shows your household's adjusted gross income that year was \$43,083.00.
- 6) According to your NYSOH account, as of March 28, 2017, your household income was listed as \$45,890.00, consisting solely of your spouse's earnings.
- 7) You testified that your child, who is [REDACTED] of age, is a full-time student, lives at home, and has no income.
- 8) You testified that your household income for 2017 is unpredictable and cannot be projected.
- 9) You expect to take business deductions on your 2017 tax return because your spouse is self-employed.
- 10) Your application states that your family resides in [REDACTED], New York.
- 11) You, your spouse, and your child are seeking to remain enrolled in a QHP with APTC.

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

Applicable Law and Regulations

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).

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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 \$24,300.00 for a four-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)).

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 \$24,300.00 for a four-person household (81 Federal Register 4036).

Legal Analysis

The issue under review is whether NYSOH properly determined that you, your spouse, and your child were eligible for the Essential Plan and no longer eligible to receive APTC or remain enrolled in a QHP.

The application that was submitted on March 28, 2017 listed an annual household income of \$45,890.00 and the eligibility determination relied upon that information.

You expect to file your 2017 income taxes as married filing jointly and will claim two dependents on that tax return. Therefore, your family is in a four-person household for purposes of this analysis.

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 March 28, 2017 application, the relevant FPL was \$24,300.00 for a four-person household. Since an annual household income of \$45,890.00 is 188.85% of the 2016 FPL, NYSOH properly found you, your spouse, and your child to be eligible for the Essential Plan. The same outcome would apply using the household's adjusted gross income from 2016 of \$43,083.00, which is 177.30% of the 2016 FPL.

Individuals with a household income greater than 150% of the FPL or below 200% of the FPL has a \$20.00 per month premium contribution. At 188.85% of the applicable FPL, you, your spouse, and your child were properly determined to each have a \$20.00 monthly premium contribution.

Further, individuals eligible for the Essential Plan are considered to have minimum essential coverage and, therefore, do not qualify to receive APTC.

Since the March 28 and 29, 2017 eligibility determination notices properly stated that, based on the information in your NYSOH account, you, your spouse, and your child were eligible for the Essential Plan and no longer eligible to receive APTC or remain enrolled in a QHP, those notices are correct and are AFFIRMED.

If your circumstances change, such as an increase or decrease in annual projected household income for 2017, please notify NYSOH within 30 days of such change.

Decision

The March 28 and 29, 2017 eligibility determination notices are AFFIRMED.

Effective Date of this Decision: August 1, 2017

How this Decision Affects Your Eligibility

You, your spouse, and your child remain eligible to enroll in the Essential Plan.

You, your spouse, and your child are ineligible for APTC or to remain enrolled in a QHP.

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 March 28 and 29, 2017 eligibility determination notices are AFFIRMED.

You, your spouse, and your child remain eligible to enroll in the Essential Plan.

You, your spouse, and your child are ineligible for APTC or to remain enrolled in a QHP.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您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 مجاناً.

বাংলা (Bengali)

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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 महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerE kasa a woka no ase ama wo kwa a wontua hwee.

(Urdu) اردو

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم 1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען אייך געבן א דאלמענטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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