



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

Notice of Decision

Decision Date: September 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019086

[REDACTED]

Dear [REDACTED],

On August 24, 2017, you and your spouse appeared by telephone at a hearing on your appeal of NY State of Health's May 20, 2017 eligibility determination.

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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Decision

Decision Date: September 18, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019086



Issue

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

Did NY State of Health properly determine that you were eligible to purchase a qualified health plan at full cost, effective July 1, 2017?

Procedural History

On May 18, 2017, NYSOH received your application for health insurance. That day, a preliminary eligibility determination was prepared with regard to that application, stating that you were eligible to enroll in a qualified health plan at full cost.

Also on May 18, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were not eligible for financial assistance.

On May 19, 2017, NYSOH issued an eligibility determination notice based on the information contained in the May 18, 2017 application, stating you were eligible to purchase a qualified health plan at full cost effective July 1, 2017. The notice further stated that you were not eligible to receive advance premium tax credits (APTC) or eligible for the Essential Plan because you were already enrolled in or eligible to enroll in an employer-sponsored health insurance that is affordable and meets minimum value.

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On August 24, 2017, you and your spouse had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until September 11, 2017 to allow you time to submit supporting documentation.

Also on September 11, 2017, you faxed a seven-page document, which included your paystubs, a print out of a bank account statement, and a handwritten note stating that you were no longer being charged for health insurance from your place of employment.

Findings of Fact

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

- 1) You are seeking insurance only for yourself.
- 2) The application that was filed on May 18, 2017 listed an annual household income of \$34,560.00, consisting of \$9,360.00 you earn from your employment, and \$25,200.00 your spouse receives in social security retirement benefits. Your spouse testified that this was incorrect.
- 3) Your spouse testified that he receives monthly income from annuities and a pension, as well as his social security retirement benefits. He testified that he receives \$1,070.67 monthly in annuity payments, and \$2,066.68 monthly in pension payments, along with \$2,100.00 he receives from his monthly social security retirement benefits.
- 4) The application that was filed on May 18, 2017 indicated that you were enrolled into coverage under an employer-sponsored health plan, effective January 1, 2017.
- 5) You testified, and the application indicates, that this coverage only includes outpatient services, and not inpatient services.
- 6) You testified that you were not sure how much your monthly premium payment was for your employer-sponsored health plan, or whether it is being deducted from your paycheck.
- 7) You testified that you are not sure if you are still enrolled in your employer's health insurance plan.
- 8) The Hearing Officer left the record open for you to submit proof of what your health insurance premium payment would be for a self-only plan through your employer, as well as recent income documentation for you and your spouse.

- 9) You submitted documentation in the form of a self-attesting letter that states that you were informed by your employer's health plan that the premium payments were no longer being deducted from your paycheck, but you did not provide proof of how much that premium would be if you were enrolled.
- 10) You submitted three of your weekly paystubs; dated August 10, 2017, August 24, 2017, and August 31, 2017, and you submitted a print out of a bank account statement indicating deposits and withdrawals on the account.
- 11) You testified that the insurance through your employer does not provide you with hospital coverage, and does not cover all of your medical bills.
- 12) You testified that you are unable to afford your employer-sponsored health insurance premium payments, and would like to be eligible to enroll in a program which is more affordable and provides more coverage.

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).

Advance Payments of the Premium Tax Credit

An APTC is 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 Federal Poverty Line (FPL),

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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 (45 CFR § 155.305(f)).

Employer-Sponsored Insurance

An employee who may enroll in an employer-sponsored health insurance plan and an individual who may enroll in the plan because of a relationship to the employee are considered eligible for minimum essential coverage as long as the plan “is affordable and provides minimum value” (26 CFR § 1.36B-2(c)(3)(i)).

An eligible employer-sponsored plan is “affordable” if the portion of the annual premium that the employee or related individual must pay for self-only coverage does not exceed the required contribution. The required contribution percentage is 9.69% of the employee’s household income for 2017 (26 CFR §1.36B-2(c)(3)(v), 26 CFR §1.36B-2T, IRS Rev. Proc. 2016-24).

Legal Analysis

The issue is whether NYSOH properly determined that you were eligible to purchase a qualified health plan at full cost, effective July 1, 2017.

In the eligibility determination notice issued on May 19, 2017, NYSOH found you ineligible for the Essential Plan, and APTC because you were either enrolled in an employer-sponsored health insurance, or you were eligible to enroll in employer-sponsored health insurance that is affordable and meets minimum value.

During the hearing, you testified that you were unsure if you were still enrolled in your employer-sponsored health insurance, and that you were unsure as to how much your employer-sponsored health insurance premium payment costs. You further testified that your employer-sponsored health insurance only covered outpatient services, and does not cover many of your medical bills. You further testified that you would like to be found eligible to enroll in a health plan which covers outpatient services, as well as inpatient services.

An employee or a related individual to the employee, who is eligible to enroll in an employer-sponsored health insurance plan that is affordable and provides minimum value, is not eligible for advance premium tax credits or the Essential Plan through NYSOH.

Employer-sponsored health insurance coverage is considered to be affordable if it costs no more than 9.69% of the household income. NYSOH uses the amount you would pay for self-only coverage through an employer to calculate whether or not a plan is affordable.

The application that was filed on May 18, 2017 listed an annual household income of \$34,560.00, consisting of \$9,360 you earn from your employment, and \$25,200.00 your spouse receives in social security retirement benefits.

During the hearing, you spouse testified that his expected income as it was listed in the May 18, 2017 application was incorrect. He testified that along with the \$2,100.00 he receives in social security retirement benefits, he also receives additional income from pension and annuities. He testified that he receives \$1,070.67 monthly in annuity payments, and \$2,066.68 monthly in pension payments, along with \$2,100.00 he receives from his monthly social security retirement benefits

The Hearing Officer left the record open until September 11, 2017 to allow you time to submit documentation which indicates the premium cost of a self-only plan through your employer-sponsored health insurance, as well as recent income documentation for you and your spouse.

On September 11, 2017, NYSOH's Appeals Unit received a seven-page fax from you that contained three of your paystubs, a print-out of a bank account statement from [REDACTED], and a self-attesting letter stating that you were informed by your employer-sponsored health insurance plan that premium payments were no longer being deducted from your pay.

You submitted a print out of a bank ledger from [REDACTED] account. A bank ledger is acceptable proof of income for pension and annuity payments. Therefore, this documentation is not sufficient to calculate your spouse's expected monthly income.

As of the date of this decision, you have not provided documentation which indicates the amount your employer-sponsored health insurance premium for a self-only plan would be, even though you may not be currently enrolled, nor have you provided sufficient income documentation to confirm your spouse's testimony of his expected monthly income.

Therefore, without sufficient documentation of your expected annual household income, nor sufficient documentation to verify the cost of a self-only plan through your employer-sponsored health insurance, the Appeal's Unit is unable to come to a conclusion as to whether NYSOH properly determined that you were ineligible for the Essential Plan and APTC because you are enrolled in, or eligible to enroll in an employer-sponsored health insurance plan that is affordable and meets minimum value.

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Therefore, the May 20, 2017 eligibility determination is AFFIRMED.

Decision

The May 20, 2017 eligibility determination is AFFIRMED.

Effective Date of this Decision: September 18, 2017

How this Decision Affects Your Eligibility

You remain eligible for a full price qualified health plan.

The Appeals Unit is unable to decide whether NYSOH properly determined you ineligible for the Essential Plan or APTC because the necessary documentation, indicating the cost of the premium for a self-only plan through your employer-sponsored health insurance, has not been submitted to date. For your eligibility to be redetermined by NYSOH, you must submit the proper documentation.

If you submit the proper documentation and update your NYSOH account, NYSOH will redetermine your eligibility accordingly.

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:

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 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 May 20, 2017 eligibility determination is AFFIRMED.

You remain eligible for a full price qualified health plan.

The Appeals Unit is unable to decide whether NYSOH properly determined you ineligible for the Essential Plan or APTC because the necessary documentation, indicating the cost of the premium for a self-only plan through your employer-sponsored health insurance, has not been submitted to date. For your eligibility to be redetermined by NYSOH, you must submit the proper documentation.

If you submit the proper documentation and update your NYSOH account, NYSOH will redetermine your eligibility 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).

Legal Authority

We are issuing this determination 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)

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।

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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 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&etumi 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 דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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