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

Notice of Decision

Decision Date: November 3, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000019770

Dear [redacted],

On September 15, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 14, 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.

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nystateofhealth
The Official Health Plan Marketplace

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

Decision

Decision Date: November 3, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000019770

[redacted]

Issues

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

> Did NY State of Health properly determine that you were eligible to receive up to $189.00 per month in advance payments of the premium tax credit, effective July 1, 2017?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were not eligible for the Essential Plan?

Procedural History

On February 17, 2017, your NYSOH account was updated. A preliminary eligibility determination was made that same day finding you eligible for the Essential Plan with no premium for a limited time, effective April 1, 2017. The notice directed you to submit proof of income by May 18, 2017 to confirm your eligibility. You were enrolled in an Essential Plan with MVP Heath Care, effective April 1, 2017.

A series of redetermination followed based on your updated applications and NYSOH's recalculations of your income.

On June 15, 2017, based on a systematic update on June 14, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for a tax

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credit of up to $189.00 per month, effective July 1, 2017, based on a household income of $33,176.50.

On June 15, 2017, you spoke to NYSOH's Account Review Unit and appealed being found eligible to receive monthly APTC and not eligible for the Essential Plan.

On June 18, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with $0 monthly premium for a limited time in that you had been granted Aid to Continue until a decision is made on your appeal. This eligibility was made effective July 1, 2017. According to a June 20, 2017 plan enrollment notice, you were re-enrolled into your Essential Plan 2, effective July 1, 2017

On September 15, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to allow you to submit supporting documents.

The Appeals Unit received a copy of your 2016 individual federal tax return (Form 1040), which document was made part of the record as "Appellant's Exhibit A." The record is now closed.

Findings of Fact

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

1) According to your NYSOH account and testimony, you expect to file your 2017 taxes with a tax filing status of single. You will not claim any dependents on that tax return.

2) You are seeking insurance for yourself.

3) In a series of updates that followed your February 16, 2017 application, you updated your income information on your online account and then NYSOH recalculated your income and found you eligible for different insurance affordability programs as follows:

    a) On May 30, 2017, you updated your income to $16,900.00 and were redetermined eligible for the Essential Plan with no premium, effective July 1, 2017;
    b) That same day, NYSOH verified your income and increased it to $29,601.52, based on proof of income you provided. You were redetermined eligible for APTC and cost-sharing reductions (CSR), effective July 1, 2017;

c) On June 5, 2017, you updated your income to $19,000.00 and were redetermined eligible for the Essential Plan with a $20.00 monthly premium, effective July 1, 2017;
d) On June 6, 2017, you updated your income to $19,500.00. That same day, NYSOH deemed your income to be invalid and increased your income to $29,601.52;
e) On June 9, 2017, NYSOH changed your income to $26,916.55 based on documents you uploaded that day. NYSOH redetermined you to be eligible for APTC of $275.00 per month and CSR, effective July 1, 2017;
f) On June 14, 2017, NYSOH updated your income and increased it from $26,916.55 to $33,176.50.

4) You testified that you expect your 2017 gross income to be between approximately $19,000.00 to $19,500.00, because you work as a [redacted] for a [redacted] only 10 months out of the year. You further testified that you get your last pay check for the end of a [redacted] in June 2017 and the next pay check is issued in September 2017, such that you go over two months without any pay.

5) You submitted your 2016 Form 1040EZ, Income Tax Return For Single…with No Dependents, which shows your gross income was $19,786.10 that year before deductions.

6) Your application states that you live in [redacted], New York.

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).

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 $11,880.00 for a one-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)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible for APTC of up to $189.00 per month and not eligible for the Essential Plan, effective July 1, 2017.

In the application that was updated on June 14, 2017, NYSOH recalculated your income to be $33,176.50. However, the record supports that this amount was calculated based on 12 months of gross income, when you credibly testified that you worked about 10 months out of the year as a [redacted] for [redacted]. To substantiate your annual earnings, you provided your 2016 Form 1040EZ, which showed annual gross earnings of $19,786.10.

According to your updated applications on June 5, 2017 and June 6, 2017, you listed your income as $19,00.00 and $19,500.00 respectively, and credibly testified that you expected your 2017 gross earnings to be comparable.

Therefore, the record reflects that NYSOH miscalculated your annual household income to be $33,176.50, such that your eligibility for APTC was made in error. As such, the June 15, 2017 eligibility determination notice is incorrect and is RESCINDED.

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 application, the relevant FPL was $11,880.00 for a one-person

household. Therefore, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, as of June 14, 2017, using a one-person household for an individual residing in , New York with an annual household income of $19,500.00, and to notify you accordingly.

Decision

The June 15, 2017 eligibility determination notice was based on an inaccurate household income, such that it was incorrect and is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, as of June 14, 2017, using a one-person household for an individual residing in , New York with an annual household income of $19,500.00, and to notify you accordingly.

Effective Date of this Decision: November 3, 2017

How this Decision Affects Your Eligibility

Your household income was miscalculated such that your eligibility for APTC is not supported by the record.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based upon the household size and income noted above. NYSOH will notify you of its redetermination.

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

- By fax: 1-855-900-5557

Summary

The June 15, 2017 eligibility determination notice was based on an inaccurate household income, such that it was incorrect and is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, as of June 14, 2017, using a one-person household for an individual residing in [redacted], New York with an annual household income of $19,500.00, and to notify you accordingly.

Your household income was miscalculated such that your eligibility for APTC is not supported by the record.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based upon the household size and income noted above. NYSOH will notify you of its redetermination.

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)

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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 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۔

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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