



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

Notice of Decision

Decision Date: October 19, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000020643

[REDACTED]

Dear [REDACTED],

On October 5, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 17, 2017, eligibility determination; July 17, 2017, disenrollment; and July 20, 2017 eligibility determination notices.

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 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.



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

Decision

Decision Date: October 19, 2017

NY State of Health Account ID [REDACTED]
Appeal Identification Number: AP000000020643

[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 that you were newly eligible to purchase a qualified health plan at full cost as of July 17, 2017, because you failed to renew your health coverage?

Did NYSOH properly determine that you were eligible for \$249.00 per month in advance payments of premium tax credit (APTC) as of July 20, 2017?

Did NYSOH properly determine that you were ineligible for the Essential Plan as of July 20, 2017?

Did NYSOH properly end your Essential Plan coverage as of July 31, 2017?

Procedural History

On October 20, 2016, NYSOH issued a notice stating that based on federal and state data sources, you qualified for the Essential Plan with a \$20.00 monthly premium. The notice stated you were re-enrolled in your current health plan, Healthfirst, with a start date of January 1, 2017.

On December 17, 2016, NYSOH issued an enrollment notice confirming that you were enrolled in an Essential Plan with an enrollment start date of January 1, 2017.

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).

On June 18, 2017, NYSOH issued a notice that it was time to renew your health insurance. That notice stated that based on the information from federal and state sources, NYSOH could not make a decision about whether you qualified for financial help paying for your health coverage, and you needed to update your account by July 15, 2017 or you might lose the financial assistance you were currently receiving.

On July 16, 2017, your account was systemically updated.

On July 17, 2017, NYSOH issued an eligibility determination notice stating that you were newly eligible to purchase a qualified health plan at full cost, effective August 1, 2017. The notice stated that you were ineligible for financial assistance because you did not renew your coverage within the proper timeframe.

Also on July 17, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end on July 31, 2017, because you no longer were eligible to enroll in the Essential Plan.

On July 19, 2017, your account was updated.

Also on July 19, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your Essential Plan coverage ending as of July 31, 2017.

On July 20, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for a tax credit up to \$249.00 per month, effective as of September 1, 2017. The notice also stated that you were ineligible for the Essential Plan because your income exceeded the income threshold.

On July 22, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a \$20.00 premium for a limited time, effective as of August 1, 2017. You had been granted Aid to Continue until a decision was made regarding your appeal.

On October 5, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was closed at the end of the hearing.

Findings of Fact

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

- 1) You were determined eligible for and enrolled in an Essential Plan, effective January 1, 2017.

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).

- 2) On June 18, 2017, NYSOH issued a renewal notice indicating that you needed to update your account by July 15, 2017, for your financial assistance to be continued (Document [REDACTED]).
- 3) According to your account and testimony, you are applying for health insurance coverage for yourself.
- 4) According to your July 19, 2017 application, you attested to filing a 2017 federal income tax return, with the tax status of single, and did not expect to claim any dependents on that tax return.
- 5) According to your July 19, 2017, application and testimony, your expected 2017 income is \$30,000.00.
- 6) According to your account, you did not expect to claim any deductions on your 2017 federal income tax return.
- 7) According to your account, you reside in [REDACTED], New York.
- 8) You testified that you expect to claim your [REDACTED], [REDACTED], as a dependent on your 2017 federal income tax return.

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

Applicable Law and Regulations

Essential Plan - Renewal

New York State has elected to redetermine Essential Plan enrollees every 12 months from the effective date of eligibility as long as enrollees are under age 65, are not enrolled in minimum essential coverage, and remain state residents. An individual enrolled in the Essential Plan shall have his or her coverage continued until the end of the 12-month period, provided he or she does not lose eligibility by reason of citizenship status, lack of state residence, failure to provide a valid social security number, providing inaccurate information that would affect eligibility when requesting or renewing health coverage, failure to make the applicable premium payment, or changes in circumstances (42 CFR § 600.340(f); NY Social Services Law § 369-gg(3) and (4)(d)).

Enrollees are required to report changes in circumstances within 30 days, which NYSOH will assess and act upon accordingly (New York's Basic Health Plan Blueprint, p. 17, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

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).

Essential Plan - Redetermination During a Benefit Year

NYSOH requires that enrollees report any change with respect to their eligibility within 30 days of such change (42 CFR § 600.340(a), 45 CFR § 155.330(b)). NYSOH must implement changes resulting from a redetermination effective the first day of the month after NYSOH is notified of the change. However, NYSOH must implement a change that results in a decreased amount of financial assistance, and for which the date of the notice is after the 15th of the month, to be effective on the first day of the second month after NYSOH has been notified of the change (45 CFR §§ 155.330(f)(1)(iii), 155.330 (f)(3), New York's Basic Health Plan Blueprint, p. 18, as approved January 2016; see <https://www.medicaid.gov/basic-health-program/basic-health-program.html>).

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)).

The maximum amount of APTC that can be authorized equals:

- 1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

minus

- 2) the taxpayer's expected contribution amount

(see 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

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 \$11,880.00 for a one-person household (81 Federal Register 4036).

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).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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).

Essential Plan - Eligibility

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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were newly eligible to purchase a qualified health plan at full cost, as of July 17, 2017, because you did not complete your renewal.

You were determined eligible for and enrolled in an Essential Plan as of January 1, 2017.

On June 18, 2017, NYSOH issued a renewal notice stating that based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health

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).

coverage, and that you needed to update your account by July 15, 2017, or you may lose your financial assistance.

No updates were made to your account by July 15, 2017, and on July 16, 2017, NYSOH redetermined your eligibility for financial assistance.

New York State has elected to redetermine Essential Plan enrollees every 12 months from the effective date of eligibility as long as enrollees are under age 65, are not enrolled in minimum essential coverage, remain state residents. An individual enrolled in the Essential Plan shall have his or her coverage continued until the end of the 12-month period, provided there are no changes in their circumstances. Enrollees are required to report changes in circumstances within 30 days, which NYSOH will assess and act upon accordingly.

Based on the foregoing, NYSOH improperly redetermined your eligibility for financial assistance on July 16, 2017. Therefore, the June 17, 2017, eligibility determination notice stating that you were no longer eligible for financial assistance because you did not respond to the renewal notice is **RESCINDED**.

The second issue under review is whether NYSOH properly determined that you were eligible for up to \$249.00 of APTC per month as of July 20, 2017.

Based on the application that was submitted on July 19, 2017, you attested to an expected annual household income of \$30,000.00, and the July 20, 2017 eligibility determination relied upon that information.

For an individual who expects to file a federal income tax return, the household equals the taxpayers and the number of individuals for whom the taxpayer is claiming as a dependent.

You attested that you expect to file a 2017 federal income tax return with the tax status of single, and did not expect to claim any dependents on that tax return. Therefore, you were in a one-person household.

You reside in [REDACTED], New York, where the second lowest cost silver plan available for an individual through NYSOH costs \$456.46 per month.

An annual income of \$30,000.00 is 252.53% of the 2016 FPL for a one-person household. At 252.53% of the FPL, the expected contribution is 8.28% of the household income, or \$207.00 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county (\$456.46 per month) minus your expected contribution (\$207.00 per month), which equals \$249.46 per month. Therefore, rounding to the nearest

dollar, NYSOH correctly determined you to be eligible for up to \$249.00 per month in APTC.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan.

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. Since an annual household income of \$30,000.00 is 252.52% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The July 20, 2017 eligibility determination properly stated that, based on the information you provided on July 19, 2017, you were eligible for up to \$249.00 per month in APTC and ineligible for the Essential Plan. Therefore, it is correct and AFFIRMED.

The fourth issue under review is whether NYSOH properly ended your Essential Plan coverage effective July 31, 2017.

An enrollee must report any change to NYSOH that may affect their eligibility. Generally, when individuals change the information in their account, any change resulting from that update will be effective the first day of the month after NYSOH is notified of the change. However, NYSOH must implement a change that results in a decreased amount of financial assistance, and for which the date of the notice is after the 15th of the month, to be effective on the first day of the second month after NYSOH has been notified of the change.

The record reflects that on July 19, 2017, you updated your account and attested to an annual household income of \$30,000.00. The update to your account resulted in a reduction in financial assistance, and the corresponding notice to this effect was issued on July 20, 2017. Therefore, your Essential Plan coverage should have ended as of August 31, 2017.

Therefore, the July 17, 2017, disenrollment notice is MODIFIED to state that your Essential Plan coverage would end August 31, 2017.

As such, your case is RETURNED to NYSOH to reinstate your Essential Plan coverage from August 1, 2017, through August 31, 2017, and to notify you accordingly.

During the hearing, you testified that you expect to claim your [REDACTED] as a dependent on your 2017 federal income tax return. If this is the case, you will need to contact NYSOH to update your application and add [REDACTED] as a dependent on your NYSOH account. NYSOH can then recalculate your eligibility

for financial assistance based on your new household size for an individual living in [REDACTED], New York, with an expected household income of \$30,000.00.

Decision

The July 17, 2017 eligibility determination is RESCINDED.

The July 17, 2017 disenrollment notice is MODIFIED to state that your Essential Plan coverage would end August 31, 2017.

The July 20, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate your Essential Plan coverage from August 1, 2017, through August 31, 2017, and to notify you accordingly.

You need to contact NYSOH to update your application and add [REDACTED] as a dependent on your NYSOH account, if you intend to claim her as a dependent on your 2017 federal tax return.

Effective Date of this Decision: October 19, 2017

How this Decision Affects Your Eligibility

Your case has been returned to NYSOH to reinstate your Essential Plan coverage from August 1, 2017 through August 31, 2017. NYSOH will notify you once this is done.

You are no longer eligible to remain enrolled in the Essential Plan as of August 31, 2017.

You remain eligible for up to \$249.00 monthly of APTC, effective September 1, 2017.

You have Aid to Continue in your Essential Plan, effective August 1, 2017, pending the outcome of this appeal, which will remain in effect until NYSOH is able assist you in selecting a qualified health plan and so as to ensure there is no gap in coverage.

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.

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 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

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).

Summary

The July 17, 2017 eligibility determination is RESCINDED.

The July 17, 2017 disenrollment notice is MODIFIED to state that your Essential Plan coverage would end August 31, 2017.

The July 20, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to reinstate your Essential Plan coverage from August 1, 2017, through August 31, 2017, and to notify you accordingly.

You need to contact NYSOH to update your application and add [REDACTED] as a dependent on your NYSOH account, if you intend to claim her as a dependent on your 2017 federal tax return.

Your case has been returned to NYSOH to reinstate your Essential Plan coverage from August 1, 2017 through August 31, 2017. NYSOH will notify you once this is done.

You are no longer eligible to remain enrolled in the Essential Plan as of August 31, 2017.

You remain eligible for up to \$249.00 monthly of APTC, effective September 1, 2017.

You have Aid to Continue in your Essential Plan, effective August 1, 2017, pending the outcome of this appeal, which will remain in effect until NYSOH is able assist you in selecting a qualified health plan and so as to ensure there is no gap in coverage.

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।

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 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 okyerε 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.

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).