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

Notice of Decision

Decision Date: October 31, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000020931

[redacted]

Dear [redacted],

On October 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 28, 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 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: October 31, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020931

[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 were eligible to enroll in a full cost qualified health plan, effective September 1, 2017?

Procedural History

On May 27, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for a full cost qualified health plan, effective July 1, 2017.

On July 13, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in a full cost qualified health plan with a monthly premium of $471.15, effective June 1, 2017.

On July 27, 2017, NYSOH received your application for health insurance. That day, a preliminary eligibility determination prepared regarding that application, stating that you were eligible to enroll in a full cost qualified health plan, effective September 1, 2017.

Also on July 27, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were found ineligible for APTC.

On July 28, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in a full cost qualified health plan, effective September 1, 2017. The notice stated that based on your income of $55,612.00, you do not qualify for Medicaid or Child Health Plus, or to receive a tax credit, because the

income you told us in your application is over the allowable income limit for these programs.

On October 3, 2017, NYSOH issued a disenrollment notice stating that coverage in your qualified health plan was ending effective, July 31, 2017 because you did not pay your insurance bill.

On October 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 single. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself.

3) Your July 27, 2017 application attested to having an annual expected household income for 2017 of $55,612.00. You testified that this was not correct because you lost your job on May 12, 2017 and began receiving unemployment benefits shortly thereafter.

4) You testified that you called NYSOH July 27, 2017 to advise that your annual income had changed but that a NYSOH representative advised you that your eligibility could only be determined using an annual income of $55,612.00.

5) You testified and NYSOH records reflect, that beginning January 1, 2017 you were employed by [redacted]. You testified and NYSOH records reflect that you had gross income for 2017 from your job at [redacted] (January 1, 2017 through April 2017) of $18,537.32.

6) You testified that you lost your job at [redacted] on May 12, 2017.

7) You testified and NYSOH records reflect that you received a final check on May 15, 2017 from your former employer ([redacted]) consisting of $2,317.16 in gross wages (for the weeks ending May 5, 2017 and May 12, 2017) and payment for 15 vacation days and 3 personal days resulting in the amount of the final check being $4,634.33. This results in your gross income from your former employer for 2017 of $23,171.65.

8) You testified and NYSOH records reflect that you began receiving unemployment benefits in the amount of $430.00 per week on May 28,

2017. You testified that you will receive 26 weekly payments of $430.00 which equals $11,180.00 in income. You testified that that your unemployment insurance benefits are scheduled to end effective November 19, 2017. This results in an anticipated 2017 gross income which includes (income from your former employer and unemployment benefits) of $34,351.65.

9) You provided a letter from your former employer [redacted] stating that your employment separation date was May 12, 2017 and that you would be paid for 15 vacation days and 3 personal days.

10) You provided a Department of Labor Unemployment Insurance Benefit Statement reflecting that your unemployment benefit claim (with a weekly payment amount of $430) began May 15, 2017.

11) You testified that you had coverage in your full cost qualified health plan from June 1, 2017 through July 31, 2017. You testified that you could not afford to continue to be enrolled in a full cost qualified health plan due to your income. This resulting in you not being able to pay your monthly premiums and in your loss of coverage effective July 31, 2017.

12) You testified that you are concerned because you do not currently have health insurance coverage, that you have not found a job and that your unemployment insurance benefits end, effective November 19, 2017.

13) You reside in [redacted], NY.

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

Applicable Law and Regulations

Verification of Eligibility for Advance Payments of the 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), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

NYSOH may not authorize APTC when it was paid on behalf of the tax filer or it's spouse, for a year which the tax data would be utilized for verification of

household income and size, and that tax filer and his spouse did not file a tax return for that year (45 CFR § 155.305(f)(4)).

An applicant is required to attest to their household's projected annual income for purposes of determining their eligibility for APTC (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

NYSOH must provide the applicant with notice of the inconsistency in their account and 90 days to provide satisfactory documentary evidence to resolve the inconsistency (45 CFR § 155.315 (f)(2)). If NYSOH remains unable to verify the attestation of the applicant, NYSOH must redetermine the applicant's eligibility based on the information available from the data sources unless the applicant demonstrates that they are unable to provide the required documentation (45 CFR § 155.315(f)(2), (g)).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective as of the first day of the month following the date of the notice (45 § 155.310(f), 45 CFR § 155.330(e),(f)(1)(i)).

Cost-Sharing Reductions

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

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible to enroll in a full cost qualified health plan, effective September 1, 2017.

On July 27, 2017, NYSOH received your application for health insurance. On July 28, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in a full cost qualified health plan, effective September 1,

2017. The notice stated that based on your income of $55,612.00 that you do not qualify for Medicaid, Child Health Plus or to receive a tax credit because the income you told us in your application is over $47,520.00, which is the allowable income limit for these programs for an individual.

You testified that your July 27, 2017 application attested to having an annual expected household income for 2017 of $55,612.00 was not correct because you lost your job on May 12, 2017 and began receiving unemployment benefits shortly thereafter.

You testified and NYSOH records reflect, that beginning January 1, 2017 you were employed by [redacted]. You testified and NYSOH records reflect that you had gross income for 2017 from your job at [redacted] (January 1, 2017 through April 2017) of $18,537.32.

You testified and NYSOH records reflect that you lost your job at [redacted] on May 12, 2017.

You testified and NYSOH records reflect that you received a final check on May 15, 2017 from your former employer ([redacted]) consisting of $2,317.16 in gross wages (for the weeks ending May 5, 2017 and May 12, 2017) and payment for 15 vacation days and 3 personal days resulting in the amount of said final check being $4,634.33. This results in your gross income from your former employer for 2017 of $23,171.65.

You testified and NYSOH records reflect that you began receiving unemployment benefits in the amount of $430.00 per week on May 28, 2017. You testified that you will receive 26 weekly payments of $430.00 which equals $11,180.00 in income. You testified that that your unemployment insurance benefits are scheduled to end, effective November 19, 2017. This results in an anticipated 2017 gross income which includes (income from your former employer and unemployment benefits) of $34,351.65.

Since the July 28, 2017, eligibility determination notice is no longer supported by the record as developed by your telephone hearing, it is RESCINDED and your case is RETURNED to NYSOH to rerun your application to ascertain your eligibility for financial assistance with health insurance as of July 27, 2017, for a one-person household with an expected annual household income of $34,351.65, for an individual residing in [redacted].

Decision

The July 28, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to rerun your application to ascertain your eligibility for financial assistance with health insurance as of July 27, 2017, for a

one-person household with an expected annual household income of $34,351.65, for an individual residing in [redacted].

Effective Date of this Decision: October 31, 2017

How this Decision Affects Your Eligibility

You will receive a new eligibility determination notice reflecting your eligibility for financial assistance as of July 27, 2017.

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 July 28, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to rerun your application to ascertain your eligibility for financial assistance with health insurance as of July 27, 2017, for a one-person household with an expected annual household income of $34,351.65, for an individual residing in [redacted].

You will receive a new eligibility determination notice reflecting your eligibility for financial assistance as of July 27, 2017.

Legal Authority

We are issuing this determination in accordance with 45 CFR § 155.545.

A Copy of this Decision Has Been Provided To:

[redacted]

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)

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).

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.

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)

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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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