



STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: December 22, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000022649

[REDACTED]

Dear [REDACTED]

On November 16, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 30, 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
PO 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(b).

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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NY State of Health Account ID: [REDACTED]
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Issues

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

Did NY State of Health (NYSOH) properly determine you were not eligible to receive advance payments of the premium tax credit (APTC), effective November 1, 2017?

Did NYSOH properly determine you were not eligible for the Essential Plan, effective November 1, 2017?

Procedural History

On September 21, 2017, NYSOH received an updated application for financial assistance with your health insurance submitted on your behalf. That day, a preliminary eligibility determination was prepared, stating you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017.

Also on September 21, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were no longer eligible for the Essential Plan.

On September 30, 2017, NYSOH issued a notice of eligibility determination, based on the September 21, 2017 application, stating you were eligible to purchase a qualified health plan at full cost, effective November 1, 2017. That notice also stated you were not eligible for the Essential Plan, because your household income was over the allowable income limit for that program.

On November 16, 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 November 30, 2017, to allow you to submit supporting documents.

As of November 30, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time 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 and you will claim no dependents on that tax return.
- 2) The application submitted on September 21, 2017, listed annual household income of \$25,000.00, consisting solely of income earned from your job at [REDACTED].” You testified that you think your income for 2017 was “probably a little more.”
- 3) You testified that you were also employed at two additional places in 2017. You testified you worked at [REDACTED] until June 2017 and that you worked at the [REDACTED] throughout 2017, but that you do not work there often anymore.
- 4) You were directed to submit proof of your income for 2017 including updated paystubs from your job at [REDACTED] and employment letters from [REDACTED] providing last date of employment and year to date gross income earned. As of the date of this decision, no such documentation has been received.
- 5) The September 21, 2017 application indicated that you were eligible to enroll in health coverage through your job at [REDACTED].
- 6) Based on the information in the September 21, 2017 application, NYSOH determined you were not eligible for financial assistance with health insurance.
- 7) You were disenrolled from your Essential Plan, effective October 31, 2017.
- 8) You testified you are seeking eligibility to enroll in the Essential Plan.

- 9) You submitted subsequent applications decreasing your attested annual income amount. You were directed to submit documentation of your income before NYSOH could determine your eligibility for health coverage. No documentation was received in response to those demands and as of November 28, 2017 you have been determined ineligible to enroll in health coverage through NYSOH.
- 10) You testified, and your applications indicate, you will not be taking any deductions on your 2017 tax return.
- 11) Your applications indicate you live in Suffolk County.

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

Applicable Law and Regulations

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 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)).

Minimum Essential Coverage

Minimum essential coverage includes most government-sponsored insurance plans such as Medicaid, Medicare, CHIP, Tricare, Veterans' Health Coverage, as well as eligible employer-sponsored insurance (26 USC § 5000A(f)).

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

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§ 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 Federal Register 4036).

Legal Analysis

The first issue is whether NYSOH properly determined you were not eligible for APTC, effective November 1, 2017.

In the application submitted on September 21, 2017, you attested to being eligible to enroll in health coverage through your job at [REDACTED] and the eligibility determination relied upon the information in that application.

Pursuant to the above cited regulations, APTC are only available to applicants not otherwise eligible for minimum essential coverage except through the individual market. Your application indicated you were eligible to enroll in health coverage through your employer. According to the regulations, minimum essential coverage includes coverage under an employer sponsored plan. Therefore, according to the information in your appeal, you were eligible for minimum essential coverage through your employer and, thus, ineligible to receive APTC.

Accordingly, NYSOH properly determined you were not eligible for APTC, effective November 1, 2017, based on your September 21, 2017 application.

The second issue under review is whether NYSOH properly determined you were no longer eligible for the Essential Plan, effective November 1, 2017.

The evidence establishes that you are in a one-person household, because you expect to file your 2017 income taxes with a tax filing status of single and you will claim no dependents.

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 the annual income amount listed in your application of \$25,000.00 is 210.44% of the 2016 FPL, NYSOH properly found you ineligible for the Essential Plan, based on the information in your application.

It is noted that during the hearing you testified to earning income at two additional employers not included in your September 21, 2017 application. You were directed to submit income documentation from all three of the employers you testified to earning income from in 2017, yet you failed to submit any such documentation. Although your testimony establishes that the subject eligibility determination is based on inaccurate income information, there is insufficient evidence in the record to overturn that determination. Moreover, it is noted that you subsequently updated your application, reducing your attested annual income amount, and you were directed to submit documentation to confirm the attested income amount prior to NYSOH issuing a determination of your eligibility. Similarly, you failed to submit the requested documentation and you have since been determined ineligible for health insurance through NYSOH. Since there is insufficient evidence of your income in the record, the Appeals Unit is unable to return your case to NYSOH for a redetermination of your eligibility for health insurance.

Decision

The September 30, 2017 eligibility determination notice is **AFFIRMED**.

Effective Date of this Decision: December 22, 2017

How this Decision Affects Your Eligibility

You were ineligible for APTC, effective November 1, 2017.

You were ineligible for the Essential Plan, effective November 1, 2017.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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:

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- By mail at:
NY State of Health Appeals
PO Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

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Summary

The September 30, 2017 eligibility determination notice is AFFIRMED.

You were ineligible for APTC, effective November 1, 2017.

You were ineligible for the Essential Plan, effective November 1, 2017.

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)

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 मददत चाहन्छि 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. yeb&tumi ama wo obi a okyer& 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.

אִיִּדִּשׁ (Yiddish)

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