



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

Notice of Decision

Decision Date: February 20, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023989

[REDACTED]

[REDACTED]

On February 2, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 1, 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
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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
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Decision

Decision Date: February 20, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023989

[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 receive an advance premium tax credit of up to \$252.00 per month, effective November 1, 2017?

Procedural History

On September 19, 2017, NYSOH received an update to your application for financial assistance with health insurance.

On September 26, 2017, NYSOH received four earnings statements issued to you by your employer, [REDACTED] between September 1, 2017 and September 22, 2017.

On September 27, 2017, NYSOH redetermined your eligibility for financial assistance with health insurance.

On September 30, 2017, NYSOH issued an eligibility determination notice stating that based on the information contained in the September 19, 2017 application, you were found eligible to enroll in the Essential Plan with a \$20.00 monthly premium for a limited time. You were requested to provide proof of your income to NYSOH by December 18, 2017 so that your eligibility could be confirmed.

On October 1, 2017, NYSOH issued an eligible determination notice based on the information contained in your account as of September 27, 2017, stating that

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you had been found eligible for an advance premium tax credit of up to \$252.00 per month, effective November 1, 2017.

On November 2, 2017, you spoke to NYSOH's Account Review Unit and appealed the October 1, 2017 eligibility determination insofar you were not found eligible for the Essential Plan.

On February 2, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and remained open as the Hearing Officer directed you to provide as additional evidence to corroborate your testimony: a letter issued by your former employer, [REDACTED], confirming your total gross earnings during 2017 and the date range worked during 2017. The record was to be closed on February 17, 2018, or upon the receipt of the above referenced documents, whichever occurred earlier.

On February 12, 2018, you provided to the NYSOH Appeals Unit through facsimile the above referenced letter issued by [REDACTED]

Accordingly, the record was closed on February 12, 2018.

Findings of Fact

A review of the record support 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 only.
- 3) The record reflects that you submitted an application to NYSOH on September 19, 2017 with the assistance of a representative at NYSOH. This application reflected an annual household income of \$23,088.00, consisting solely of earned income from [REDACTED].
- 4) In response to the September 19, 2017 application, NYSOH found you temporarily eligible for the Essential Plan with a \$20.00 monthly premium, effective November 1, 2017, pending the receipt of income documentation by December 18, 2018.
- 5) On September 26, 2017, you provided to NYSOH four earnings statements issued to you by your employer, [REDACTED], between September 1, 2017 and September 22, 2017, reflecting that you received (1) \$400.48 on September 1, 2017, (2) \$640.00 on September 8, 2017, (3) \$609.28 on September 15, 2017, and (4) \$640.00 on September 22, 2017.

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- 6) Your eligibility was redetermined by NYSOH on September 27, 2017, which found you eligible for an APTC of up to \$252.00, effective November 1, 2017. You testified that this amount was incorrect, because it over-estimated your annual income from [REDACTED] and did not account for your income from your prior employer, [REDACTED].
- 7) Your eligibility was redetermined on September 27, 2017 based on an annual household income of \$29,766.88.
- 8) You testified that you worked for [REDACTED] between January 1, 2018 and May 25, 2017.
- 9) You testified that you were hired by [REDACTED] on June 6, 2017, and remain employed at that company.
- 10) You testified that when you updated your application on September 19, 2017, the NYSOH representative was not clear on what income sources you were required to provide in filling out your application.
- 11) You testified, and your application reflects, that you will not be taking any deductions on your 2016 tax return.
- 12) You live in [REDACTED], New York.
- 13) You testified that you were seeking to be found eligible for the Essential Plan because the health plans available, even with an APTC of up to \$252.00 per month, are unaffordable.

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 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)).

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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.).

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.).

Legal Analysis

The issue under review is whether NYSOH properly determines that you were eligible to receive an advance premium tax credit of up to \$252.00 per month, effective November 1, 2017.

The application that was submitted on September 19, 2017 listed an annual household income of \$23,088.00. The application reflects, and you testified, that this income amount was reflected as your annualized earnings from your current employer, [REDACTED]. In response to this application, you were found eligible for the Essential Plan for a limited time, effective November 1, 2017. You were further requested to provide additional income documentation to NYSOH by December 18, 2017 to confirm your eligibility.

The record reflects that on September 26, 2017, you provided to NYSOH four earnings statements issued to you by your employer [REDACTED], between September 1, 2017 and September 22, 2017, reflecting that you received (1) \$400.48 on September 1, 2017, (2) \$640.00 on September 8, 2017, (3) \$609.28 on September 15, 2017, and (4) \$640.00 on September 22, 2017.

On September 27, 2017, your eligibility was redetermined based on an annual household income of \$29,766.88, which was derived from your average weekly earnings from [REDACTED] of \$572.44. Because of this redetermination, you were found eligible for an APTC of up to \$252.00 per month, effective November 1, 2017.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim not dependents on that tax return.

You testified that this annual household income was not reflective of your anticipated annual household income for 2017 since you were only employed by [REDACTED] since June 6, 2017, as reflected in each of the earnings statement provide to NYSOH on September 26, 2017.

Furthermore, you testified, and provided documentation on February 12, 2018, reflecting that you were employed by [REDACTED] beginning January 1, 2017 and ended your employment with them as of May 25, 2017. You earned \$8,672.25 during that period.

Accordingly, we find there is sufficient evidence that NYSOH calculated your annual household on a patently defective figure basing your earnings on working a full year with [REDACTED].

We find that your annual household income should have be calculated as \$25,273.01, which was comprised of the \$16,600.76 (\$572.44 x 29 weeks remaining in 2017 after your June 6, 2017 hire date) you would have received from [REDACTED] plus the \$8,672.25 you received from [REDACTED] from January 1, 2017 through May 25, 2017.

Therefore, the October 1, 2017 eligibility determination notice is no longer supported by the now developed record, and is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household in Kings County, with an annual household income of \$25,273.01, as of September 26, 2017.

Decision

The October 1, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a one-person household in Kings County, with an annual household income of \$25,273.01, as of September 26, 2017.

Effective Date of this Decision: February 20, 2018

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How this Decision Affects Your Eligibility

You will receive a new eligibility determination notice reflecting your eligibility as of as of September 26, 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 case 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.

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. 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).

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
PO Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The October 1, 2017 eligibility determination notice is RESCINDED.

Your case is being sent back to NYSOH to redetermine your eligibility based on a one-person household in Kings County, with an annual household income of \$25,273.01, as of September 26, 2017.

You will receive a new eligibility determination notice reflecting your eligibility as of as of September 26, 2017.

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، يرجى الاتصال بالرقم 1-855-355-5777. يمكننا 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&btumi 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 איך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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