



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

Notice of Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029909



Dear [REDACTED],

On May 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 19, 2018 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.

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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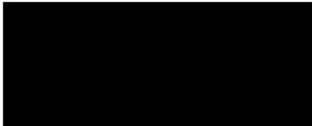


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P.O. Box 11729
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Decision

Decision Date: May 24, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000029909



Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

Did NY State of Health properly determine that you were eligible to receive up to \$136.00 per month in advance payments of the premium tax credit and ineligible to remain enrolled in the Essential Plan, effective April 1, 2018?

Procedural History

On November 13, 2017, NY State of Health (NYSOH) received your updated application for financial assistance with health insurance.

On November 14, 2017, NYSOH issued an eligibility determination notice stating, in part, that you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium for a limited time, effective December 1, 2017. The notice further directed you to submit income documentation to confirm your eligibility by February 11, 2018.

On November 14, 2017, NYSOH issued a plan enrollment notice confirming, in part, your enrollment in an Essential Plan with a \$20.00 monthly premium, effective December 1, 2017.

On November 29, 2017, you faxed a five-page document to NYSOH, which was uploaded to your NYSOH account on November 30, 2017.

On December 1, 2017, NYSOH invalidated the documentation you provided.

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 December 2, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the information in your application and that additional documentation was needed to verify the information before February 11, 2018, to confirm your eligibility.

No additional income documentation was received by February 11, 2018.

On February 19, 2018, NYSOH issued an eligibility determination notice stating, in part, that you were eligible for up to \$136.00 per month in advanced payment of the premium tax credit (APTC), effective April 1, 2018. This notice stated that you were found eligible for APTC because federal and state data sources indicate that your household income is between \$22,412.00 and \$64,960.00. This notice further stated that you were no longer eligible for the Essential Plan as of March 31, 2018.

On March 7, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were no longer eligible for the Essential Plan.

On May 4, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open until May 21, 2018, to allow you time to submit supporting income documentation.

As of May 21, 2018, 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 tax return for 2018 with a tax filing status of head of household with one qualifying individual.
- 2) You are seeking health insurance for yourself and your child.
- 3) You testified that you are only appealing your eligibility for financial assistance.
- 4) The application that was submitted on November 13, 2018, listed an expected annual household income of \$30,448.00, consisting of income you earn from your employment.

- 5) Your NYSOH indicates that you have two different employers.
- 6) On November 29, 2017, you faxed a five-page document to NYSOH. This document contained a letter from one employer and four weekly paystubs from your other employer.
- 7) On December 1, 2017, a NYSOH representative invalidated the income documentation you submitted on November 29, 2017, because the letter you submitted did not provide sufficient information to determine what your income would be for that place of employment.
- 8) No additional documentation was provided to NYSOH by February 11, 2018.
- 9) Your NYSOH account indicates that, based on federal and state data sources, you were found eligible for up to \$136.00 per month in APTC, effective April 1, 2018.
- 10) You testified that you do not know what your income for 2018 will be because you work per diem for one employer and are only able to work when you are needed by the employer.
- 11) Your application states that you will not be taking any deductions on your 2018 tax return.
- 12) Your application states that you live in [REDACTED], NY.
- 13) You testified that you are unable to afford your health insurance premium without additional financial assistance.

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

Applicable Law and Regulations

Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f) 42 CFR § 435.952).

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Advance Payments of 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), 26 CFR § 1.36B-2, 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 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is \$16,240.00 for a two-person household (82 Federal Register 8831).

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 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).

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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 2017 FPL, which is \$16,240.00 for a two-person household (82 Fed. Reg. 8831).

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/downloads/ny-blueprint.pdf>).

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 first issue under review is whether NYSOH properly determined that you were eligible for up to \$136.00 per month in APTC and ineligible to remain enrolled in the Essential Plan, effective April 1, 2018.

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence.

On November 13, 2017, NYSOH received your updated application for financial assistance with health insurance. However, the income information listed in your application did not match what NYSOH received from state and federal data sources. As a result, NYSOH directed you to submit income documentation to verify the income information listed in your application to confirm your eligibility.

On November 29, 2017, you faxed a five-page document to NYSOH, which contained a letter from your employer, dated November 15, 2017, and four of your weekly paystubs from your other employer. On December 1, 2017, a NYSOH representative invalidated the income documentation you provided because the letter from your employer did not contain sufficient information to calculate your income. Subsequently, on December 2, 2017, NYSOH issued a notice stating that the income documentation you provided was insufficient to

confirm your income information and that more documentation was needed by February 11, 2018.

No additional income documentation was submitted by February 11, 2018. Therefore, on February 19, 2018, NYSOH issued an eligibility determination, based on a February 18, 2018 application, stating in part that, based on federal and state data sources, you were eligible for up to \$136.00 per month in APTC, effective April 1, 2018. This notice further stated that you were no longer eligible for the Essential Plan, as of March 31, 2018, because data sources show that your income is over the income limits for that program.

However, instead of submitting a new application with updated income information, you filed an appeal on March 7, 2018 because you did not remain eligible for the Essential Plan and you were not found eligible for additional financial assistance with your health insurance.

You testified that you are unsure as to what your 2018 expected annual income will be because you only work per diem for your one employer. The Hearing Officer left the record open until May 21, 2018, to allow you time to submit income documentation.

As of May 21, 2018, 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.

Since you did not provide sufficient income documentation to determine your annual expected household income for 2018, the Appeals Unit has insufficient evidence to determine if the data sources that NYSOH relied upon were an accurate reflection of your expected annual household income for 2018.

As a result, there is insufficient evidence to disturb NYSOH's February 19, 2018 eligibility determination and the February 19, 2018 eligibility determination notice is **AFFIRMED**.

Please note, you can update your NYSOH to reflect your current expected annual income, at any time, as these changes may affect your eligibility for financial assistance with health insurance.

Decision

The February 19, 2018 eligibility determination notice is **AFFIRMED**.

Effective Date of this Decision: May 24, 2018

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).

How this Decision Affects Your Eligibility

Based on federal and state data sources, NYSOH determined that you were eligible for up to \$136.00 in APTC and ineligible to remain enrolled in the Essential Plan.

There is insufficient evidence in the record to disturb NYSOH decision.

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

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).

- 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 February 19, 2018 eligibility determination notice is AFFIRMED.

Based on federal and state data sources, NYSOH determined that you were eligible for up to \$136.00 in APTC and ineligible to remain enrolled in the Essential Plan.

There is insufficient evidence in the record to disturb NYSOH decision.

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)

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. 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.

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.