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

Notice of Decision

Decision Date: March 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014539

[redacted]

Dear [redacted]

On March 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 17, 2016 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 30, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014539

[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 eligible to receive up to $158.00 per month in advance payments of the premium tax credit, effective January 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan?

Procedural History

On December 17, 2015, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan for a limited time, pending the receipt of income documentation before March 15, 2016. This eligibility determination was effective January 1, 2016. You enrolled in an Essential Plan with MetroPlus Health Plan (MetroPlus) at that same time, with such coverage beginning effective January 1, 2016.

On July 30, 2016, NYSOH issued a disenrollment notice stating that your Essential Plan coverage with MetroPlus would end effective August 31, 2016.

On November 16, 2016, you submitted an application for financial assistance.

On November 17, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to receive an advance premium tax credit of up to $158.00 per month, effective January 1, 2017. That notice also stated that you were not eligible for either cost-sharing reductions or the Essential Plan because your income was over the allowable income limits for those programs.

On January 3, 2017, you spoke to NYSOH's Account Review Unit and appealed the November 17, 2016 eligibility determination notice.

On January 5, 2017, NYSOH issued an enrollment notice confirming your selection of Fidelis Care Bronze ST INN Pediatric Dental Dep25 (Fidelis Care) plan as your qualified health plan (QHP) as of January 3, 2017. The notice stated that your QHP coverage, with a monthly premium of $209.04, after applying the $158.00 APTC, would begin effective February 1, 2017.

On March 27, 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. Your account reflects that you would be claiming only your grandson as a dependent on that tax return. However, you further testified that you now intended to claim your son as a dependent since he is now living at home after having been in an accident.

2) You are seeking insurance for yourself only.

3) The application that was submitted on November 16, 2016 listed annual household income of $41,932.80, consisting solely of income you earn from your employment with [redacted] You testified that your earning rate of $9.60 per hour and 84-hour work week was accurate since you are on call around the clock at your current healthcare position. You testified that this amount was correct when provided in your application on November 16, 2016, and remains accurate.

4) You testified, and your application reflects, that your grandson is not currently receiving any income or benefits.

5) Your son is not listed anywhere within your NYSOH account, and has not been included as a person seeking insurance.

6) Your application reflects that you will not be taking any deductions on your 2017 tax return.

7) You live in Kings County, New York.

8) You testified that you were unhappy since having to pay more for insurance than you were previously paying under your MetroPlus plan, and were seeking to be reenrolled in the MetroPlus plan again.

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)).

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 $16,020.00 for a two-person household (81 Fed. Reg. 4036.).

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

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)).

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 $16,020.00 for a two-person household (81 Fed. Reg. 4036.).

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/basic-health-program.html).

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).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to $158.00 per month.

The application that was submitted on November 16, 2016 listed an annual household income of $41,932.80, consisting solely of income you earn from your employment with [redacted] You testified that your earning rate of $9.60 per hour and 84-hour work week was accurate since you are on call around the clock at your current healthcare position. The eligibility determination relied upon that information.

You are in a two-person household. As reflected in your November 16, 2016 application, you expect to file your 2017 income taxes as single and will claim only your grandson as a dependent on that tax return. At the hearing, you testified that you now also anticipate claiming your son as a dependent; however, we cannot include your son within your household at this time since he has not been included within you NYSOH account.

You reside in Kings County, where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $41,932.80 is 261.75% of the 2016 FPL for a two-person household. At 261.75% of the FPL, the expected contribution to the cost of the health insurance premium is 8.56% of income, or $299.05 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 ($299.05 per month), which equals $157.41 per month. Therefore, rounding to the nearest dollar, you would be eligible for an APTC of up to $157.00 per month.

The Marketplace computed your APTC by rounding $157.41 to the next highest dollar, $158.00. It therefore incorrectly calculated your APTC by $1.00. However, since the APTC you were determined eligible for under the November 17, 2016 is not materially greater than your actual APTC eligibility, which was due to the rounding anomaly noted above, the difference is properly reconciled as a tax liability on a federal individual income tax return.

The second issue is whether you were properly found ineligible for CSR.

CSR is available to a person who has a household income no greater than 250% of the FPL. Since a household income of $41,932.80 is 261.75% of the applicable FPL, NYSOH correctly found you to be ineligible for CSR.

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 $16,020.00 for a two-person household. Since an annual household income of $41,932.80 is 261.75% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the November 17, 2016 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to $158.00 per month in APTC, ineligible for CSR, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

Furthermore, since you testified that you now anticipate claiming your son as a dependent on your 2017 tax return, in addition to your grandson, you are encouraged to revise your application by contacting NYSOH.

Decision

The November 17, 2016 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 30, 2017

How this Decision Affects Your Eligibility

You continue to be eligible to receive up to $158.00 per month of APTC.

Since the APTC of $158.00 per month you were determined eligible for under the November 17, 2016 determination is not materially greater than your actual APTC eligibility of $157.00 per month, which was due to a rounding anomaly, the difference is properly reconciled as a tax liability on your federal individual income tax return.

You are not eligible for either CSR or the Essential Plan.

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

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Summary

The November 17, 2016 eligibility determination notice is AFFIRMED.

You continue to be eligible to receive up to $158.00 per month of APTC.

Since the APTC of $158.00 per month you were determined eligible for under the November 17, 2016 determination is not materially greater than your actual APTC eligibility of $157.00 per month, which was due to a rounding anomaly, the difference is properly reconciled as a tax liability on your federal individual income tax return.

You are not eligible for either CSR or the Essential Plan.

Since you testified that you now anticipate claiming your son as a dependent on your 2017 tax return, in addition to your grandson, you are encouraged to revise your application by contacting NYSOH.

Legal Authority

We are sending you this notice 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)

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 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)

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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