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

Notice of Decision

Decision Date: May 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014883

[redacted]

Dear [redacted],

On April 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 18, 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 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: May 8, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014883

[redacted]

Issues

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

> Did NY State of Health properly determine that you and your spouse were eligible to receive up to $689.00 per month in advance payments of the premium tax credit (APTC), effective February 1, 2017?
>
> Did NY State of Health properly determine that you and your spouse were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you and your spouse were ineligible for the Essential Plan?

Procedural History

On January 17, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you were eligible to receive up to $689.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective February 1, 2017.

Also on January 17, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination for you and your spouse, insofar as you were determined ineligible for the Essential Plan.

On January 18, 2017, NYSOH issued a notice of eligibility determination, based on the January 17, 2017 application, stating that you and your spouse were eligible to receive up to $689.00 in APTC and eligible to receive cost-sharing

reductions if you enrolled in a silver level qualified health plan, effective February 1, 2017. That notice also stated that you were ineligible for the Essential Plan because your income was over the allowable income limit for that program.

On January 19, 2017, NYSOH issued an eligibility determination, stating that you and your spouse were eligible for the Essential Plan for a limited time, as your request for aid to continue was granted for the duration of your appeal.

On January 19, 2017, NYSOH issued an enrollment confirmation notice, stating that you and your spouse were enrolled in the Essential Plan with a start date of February 1, 2017.

On April 13, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, Albanian Interpreter [redacted] was conferenced in to assist in translating the hearing. The record was developed during the hearing and held open up to April 28, 2017, to allow you time to submit supporting documents.

On April 19, 2017, you faxed two of your paystubs, one of your spouse's paystubs and your and your spouse's 2016 federal tax return.

On April 21, 2017, you faxed one of your spouse's paystubs.

The record remained open until the close of business on April 28, 2017. No additional documentation was provided. The record was closed at the end of business on April 28, 2017.

Findings of Fact

A review of the record supports the following findings of fact:

1) You are seeking the Essential Plan for you and your spouse.

2) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim two dependents on that tax return.

3) The January 17, 2017 application stated that you and your spouse intend to file a tax return as married filing jointly and claim no dependents

4) The application that was submitted on January 17, 2017 listed annual household income of $36,400.00, consisting of $18,200.00 you earn from your employment and $18,200.00 your spouse earns from his employment. You testified that you each have an annual income of approximately $20,000.00.

5) You testified that you and your spouse anticipate earning less in 2017 than in 2016, as you both plan to work fewer hours.

6) You testified that you and your spouse are paid biweekly, and that your pay varies from paycheck to paycheck.

7) The record contains the following paystubs for you:
    a. Dated February 17, 2017 for a gross pay amount of $979.00.
    b. Dated March 31, 2017 for a gross pay amount of $891.00.
    c. Dated April 14, 2017 for a gross pay amount of $838.75.

8) The record contains the following paystubs for your spouse:
    a. Dated February 17, 2017 for a gross pay amount of $1,399.75.
    b. Dated March 3, 2017 for a gross pay amount of $1,028.75.
    c. Dated March 31, 2017 for a gross pay amount of $1,276.00
    d. Dated April 14, 2017 for a gross pay amount of $1,012.00.

9) You did not submit all paystubs for you and your spouse from March 2017.

10) You submitted your 2016 Federal tax return, which states that your household's gross income for 2016 was $42,530.00, and that you claimed both of your children as dependents.

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

12) Your application states that you live in Bronx 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 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 and $24,300.00 for a four-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

<u>Cost-Sharing Reductions</u>

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)).

<u>Essential Plan</u>

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 and $24,300.00 for a four-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).

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 is whether NYSOH properly determined that you and your spouse were eligible for an APTC of up to $689.00 per month.

The application that was submitted on January 17, 2017 listed an annual household income of $36,400.00 and the eligibility determination relied upon that information. The application stated that you and your spouse intend to file a tax return as married filing jointly and claim no dependents. Since you did not list your children as dependents, NYSOH considered you and your spouse to be in a two-person household when determining the applicable FPL.

You reside in Bronx County, where the second lowest cost silver plan available for a couple through NYSOH costs $912.91 per month.

An annual income of $36,400.00 is 227.22% of the 2016 FPL for a two-person household. At 227.22% of the FPL, the expected contribution to the cost of the health insurance premium is 7.40% of income, or $224.47 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 a couple in your county ($912.91 per month) minus your expected contribution ($224.47 per month), which equals $688.44 per month. Therefore, rounding up to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to $689.00 per month in APTC.

The second issue is whether you and your spouse were properly determined eligible for cost-sharing reductions. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the FPL. Since a household income of $36,400.00 is 227.22% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you and your spouse were ineligible for the Essential Plan, effective February 1, 2017.

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 $36,400.00 is 227.22% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the January 18, 2017 eligibility determination properly stated that, based on the information you provided, you and your spouse were eligible for up to $689.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan it is correct and is AFFIRMED.

However, you testified and provided documentation to show that you and your spouse claimed your children as dependents, and that your household earned a gross annual income of $42,530.00 in 2016. Although you testified that you expect to earn less income in 2017, you did not provide sufficient documentation by way of paychecks to support that.

Your case is RETURNED to NYSOH to update your application to indicate that you will be claiming your two children as dependents and to redetermine your and your spouse’s eligibility based on an annual expected income of $42,530.00 with a household size of four people residing in Bronx County.

Decision

The January 18, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to update your application to indicate that you will be claiming your two children as dependents and to redetermine your and your spouse's eligibility based on an annual expected income of $42,530.00 with a household size of four people residing in Bronx County.

Effective Date of this Decision: May 8, 2017

How this Decision Affects Your Eligibility

NYSOH properly determined you and your spouse eligible for up to $689.00 in APTC.

NYSOH properly determined you and your spouse eligible for cost-sharing reductions.

NYSOH properly determined you and your spouse ineligible for 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.

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:

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 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

Summary

The January 18, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined you and your spouse eligible for up to $689.00 in APTC.

NYSOH properly determined you and your spouse eligible for cost-sharing reductions.

NYSOH properly determined you and your spouse ineligible for the Essential Plan.

Your case is RETURNED to NYSOH to update your application to indicate that you will be claiming your two children as dependents and to redetermine your and your spouse's eligibility based on an annual expected income of $42,530.00 with a household size of four people residing in Bronx County.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

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A Copy of this Decision Has Been Provided To:

[redacted]

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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।

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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 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.

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).