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

Notice of Decision

Decision Date: April 25, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015244

[redacted]

Dear [redacted]

On April 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 28, 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: April 25, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015244

[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 $118.00 per month in advance payments of the premium tax credit (APTC), effective March 1, 2017?
>
> Did NYSOH properly determine that you were not eligible for cost-sharing reductions?
>
> Did NYSOH properly determine you were not eligible for the Essential Plan?

Procedural History

On January 27, 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 $118.00 per month in APTC, effective March 1, 2017.

Also on January 27, 2017, you spoke to NYSOH's Account Review Unit and appealed the preliminary eligibility determination, insofar as you were not found eligible for the Essential Plan. You also requested Aid to Continue, pending the outcome of your appeal.

On January 28, 2017, NYSOH issued a notice of eligibility determination, based on the January 27, 2017 application, stating that you were eligible to receive up to $118.00 per month in APTC, effective March 1, 2017. That notice also stated

that you were not eligible for cost-sharing reductions or the Essential Plan because your income was over the allowable income limits for those programs.

On February 1, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, effective March 1, 2017. This was because you had been granted Aid to Continue until a decision is made on your appeal.

Also on February 1, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan, with a plan start date of March 1, 2017. This was because you were granted Aid to Continue, pending the outcome of your appeal.

On April 20, 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 until May 5, 2017, to allow you time to submit supporting documents.

On April 20, 2017, you sent a two-page fax to the NYSOH Appeals Unit, and indicated on the fax that you do not plan to send any further documentation. The record is now closed.

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. You will claim no dependents on that tax return.

2) The application that was submitted on January 27, 2017 listed annual household income of $41,600.00 consisting of earned income from employment. This amount was based on a job paying $20.00 an hour for 40 hours a week.

3) You testified that, when you completed your application, you informed the NYSOH representative that your job was temporary, and that you expected it to end soon, but that the representative based your annual income on the money you were earning from the temporary job you were working at that time.

4) You testified that you worked that particular temporary job for approximately eight or nine months, and that your last day was February 17, 2017, and you received your last paycheck from that position on March 2, 2017.

5) You testified that you filed for Unemployment Insurance Benefits (UIB) immediately after that job ended.

6) You testified that your claim was approved, but you stopped claiming for approximately three weeks because you had another temporary job.

7) You testified that this job ended on March 17, 2017, and so you began claiming UIB.

8) You testified that you receive a weekly benefit of $375.00 gross from UIB, and that it is currently your only source of income, and has been since your last temporary job ended on March 17, 2017.

9) You testified that you do not currently have any other jobs scheduled at this time.

10) After the hearing, you faxed a two-page document to NYSOH consisting of a fax cover sheet and an Official Record of Benefit Payment History from NY State Unemployment Insurance. The payment history shows that you filed your claim for UIB on February 20, 2017, and that you received your first $375.00 payment on March 27, 2017. It further shows that you have been receiving $375.00 each week since that first payment, and that the maximum amount payable to you through February 25, 2018 is $9,750.00. This document is marked and entered into the record as “Appellant’s Exhibit One.”

11) Your application states that you will not be taking any deductions on your 2017 tax return, and you confirmed this in your testimony.

12) Your application states that you live in [redacted].

13) You testified that you are looking to be eligible for the Essential Plan instead of APTC, as you believe you are eligible for it based on your current income of UIB.

14) You testified, and the record reflects, that you have been receiving Essential Plan coverage since March 1, 2017 pursuant to NYSOH’s decision to grant you Aid to Continue, pending the outcome of this appeal.

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 $11,880.00 for a one-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 300% but less than 400% of the 2016 FPL, the expected contribution is 9.69 % 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).

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 $11,880.00 for a one-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 under review is whether NYSOH properly determined that you were eligible to receive up to $118.00 per month in APTC, effective March 1, 2017.

The application that was submitted on January 27, 2017 listed an annual household income of $41,600.00 and the eligibility determination relied upon that information. You testified that this information was correct at that time, but that it was based on a temporary job that you knew would be ending soon.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

You reside in [redacted], where the second lowest cost silver plan available for an individual through NYSOH costs $453.37 per month.

An annual income of $41,600.00 is 350.17% of the 2016 FPL for a one-person household. At 350.17% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or $335.92 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 ($453.37 per month) minus your expected contribution ($335.92 per month), which equals $117.45 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $118.00 per month in APTC, based on the information available at the time of your application.

The second issue under review is whether you were properly found ineligible 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 $41,600.00 is 350.17% of the applicable FPL, NYSOH correctly found you to be ineligible/eligible for cost sharing reductions, based on the information in your January 27, 2017 application.

The third issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan, as of your January 27, 2017 application.

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 an annual household income of $41,600.00 is 350.17% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan, based on the information in your January 27, 2017 application.

However, at the hearing you testified that you stopped working at the job that formed the basis of your expected annual income calculation, and that your last day was February 17, 2017. You further testified that you worked a three-week temporary job after that, but have not worked since March 17, 2017. You testified that the only income you currently have is from UIB, in the amount of $375.00 per week. After the hearing, you submitted documentation proving that you have been receiving $375.00 per week in UIB since March 27, 2017. The documentation also shows that the maximum amount that you can receive in UIB on your current claim is $9,750.00.

Since you worked at a position previously in 2017 that paid $20.00 an hour for 40 hours per week, that income must also be added into any income calculation for 2017. You testified that your last day at this job was February 17, 2017, which amounts to approximately six weeks at $800.00 per week. Therefore, your approximate 2017 earnings from this positon were $4,800.00. When added to the total possible benefit amount you can receive in 2017 from UIB, your expected yearly income for is $14,550.00.

Therefore, your case is RETURNED to NYSOH to immediately re-determine your eligibility for financial assistance, based on a one-person household with an expected annual income of $14,550.00, residing [redacted].

You will be promptly notified in writing of NYSOH's new eligibility determination.

Your Aid to Continue will remain in place until a new eligibility determination is issued.

Decision

The January 28, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to immediately re-determine your eligibility for financial assistance for 2017, based on a one-person household with an expected annual income of $14,550.00, residing [redacted]

NYSOH will promptly notify you in writing of the new eligibility determination.

Your Aid to Continue will remain in place until a new eligibility determination is issued.

Effective Date of this Decision: April 25, 2017

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

You were eligible for APTC of up to $118.00 per month, as of your January 27, 2017 application, and not eligible for cost-sharing reductions or the Essential Plan.

However, your case is being sent back to NYSOH to re-determine your eligibility for financial assistance for 2017, based on the updated income information you provided during and after the hearing.

You will be notified in writing of NYSOH's new eligibility determination.

Your Aid to Continue will remain in place until NYSOH issued a new eligibility determination.

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:

- 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

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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 28, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to immediately re-determine your eligibility for financial assistance for 2017, based on a one-person household with an expected annual income of $14,550.00, residing in [redacted]

NYSOH will promptly notify you in writing of the new eligibility determination.

Your Aid to Continue will remain in place until a new eligibility determination is issued.

You were eligible for APTC of up to $118.00 per month, as of your January 27, 2017 application, and not eligible for cost-sharing reductions or the Essential Plan.

However, your case is being sent back to NYSOH to re-determine your eligibility for financial assistance for 2017, based on the updated income information you provided during and after the hearing.

You will be notified in writing of NYSOH's new eligibility determination.

Your Aid to Continue will remain in place until NYSOH issued a new eligibility determination.

Legal Authority

We are sending you this notice in accordance with 45 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).

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.

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).