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

Notice of Decision

Decision Date: July 24, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000016668

[redacted]

Dear [redacted]

On June 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 7, 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: July 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000016668

[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 up to $250.00 per month in advance payments of the premium tax credit (APTC), effective March 1, 2017, and not eligible for the Essential Plan?

Procedural History

On January 30, 2017, you applied for health insurance and financial assistance through NYSOH, stating that your expected yearly income was $31,200.00.

On January 31, 2017, NYSOH issued a notice of eligibility determination, stating that you were eligible to receive up to $233.00 per month in APTC, effective March 1, 2017.

On January 31, 2017, you updated your account twice. In the first, you listed your expected annual income as $27,300.00, which resulted in a preliminary eligibility determination that you were eligible to receive up to $286.00 per month in APTC, as well as cost-sharing reductions.

In the second application filed on January 31, 2017, you lowered your expected annual income again, this time to $22,463.22.

Also on January 31, 2017, you uploaded income documentation.

On February 1, 2017, NYSOH issued a notice of eligibility determination in response to your last application on January 31, 2017. That notice stated that you were eligible to enroll in the Essential Plan, for a limited time only, but that you would need to provide documentary evidence of your income to confirm your listed income of $22,463.22 by May 1, 2017.

On February 6, 2017, your application was reconsidered, based on the two paystubs you had submitted.

On February 7, 2017, NYSOH issued a notice of eligibility determination, stating that you were eligible to receive up to $250.00 per month in APTC, effective March 1, 2017. You were no longer eligible for cost-sharing reductions.

Also on February 7, 2017, NYSOH issued an enrollment notice, advising you that your enrollment in the Essential Plan would end effective March 1, 2017.

On March 7, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination notice, insofar as you were not found eligible for the Essential Plan.

On June 8, 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 through June 22, 2017 to allow you to submit supporting documents.

On June 20, 2017, you uploaded paystubs to your NYSOH account, and the record was closed.

On June 29, 2017, you submitted a new application, in which you indicated that your annual expected earnings were $2,313.75. You were subsequently found eligible for Medicaid.

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, with no dependents.

2) You are seeking insurance for yourself.

3) On January 31, 2017, you uploaded income documentation that consisted of two biweekly paystubs issued in January 2017. The first, issued on January 12, 2017, was for a gross income of $1,173.75. The second, issued on January 26, 2017, was for a gross amount of $1,132.50.

4) On June 20, 2017, June 29, 2017, and July 12, 2017, two additional paystubs were uploaded to your account. The first, issued on February 9, 2017, was for a gross amount of $1,140.00. The second, issued on February 23, 2017 was for a gross amount of $1,140.00.

5) Your paystubs indicate you accrue personal leave, sick leave, and vacation leave.

6) You testified that you have only one job, but that your income varies with your work hours. The expected annual earnings you initially listed on your application might not have been an accurate representation of your annual earnings, because it included overtime. You also testified that the first application you submitted, with estimated annual earnings of $27,300.00 was correct; the second was incorrect, because $22,463.00 was your income after withholdings.

7) Your applications state that you will not be taking any deductions on your 2017 tax return.

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

9) You testified that you want to be found eligible for the Essential Plan instead of tax credits.

10) Your NYSOH account reflects that you are currently enrolled in a Medicaid Managed Care plan.

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 Federal Register 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).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% 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 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 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 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)).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your applications, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible to receive up to $250.00 per month in APTC, effective March 1, 2017, and not eligible for the Essential Plan.

In this case, the analysis of eligibility depends on your annual expected household earnings.

The February 6, 2017 redetermination of your eligibility relied on expected annual income of $29,981.25.

You are in a one-person household. You expect to file your 2017 income taxes as single, with no dependents.

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

An annual income of $29,981.25 is 252.37% of the 2016 FPL for a one-person household. At 252.37% of the FPL, the expected contribution to the cost of the health insurance premium is 8.28% of income, or $206.87 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 ($206.87 per month), which equals $249.59 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined that you were eligible to receive up to $250.00 per month in APTC based on that calculated income.

However, multiple incomes were included in your applications and testimony, and you testified that sometimes you used your gross earnings, and sometimes your net take home pay. Given the different amounts listed, the most reliable measure of your income are the latest paystubs you provided to the Appeals Unit of NYSOH.

The last paystub indicated that your year-to-date earnings, as of February 23, 2017, were $4,586.25. This constitutes your gross pay for the first four of 26 pay periods for 2017. Extrapolating to include the full year results in expected annual earnings for 2017 of $29,810.63, which is 250.93% of the applicable FPL for APTC and the Essential Plan.

To be eligible for the Essential Plan, your annual earnings would have to be less than 200% of the applicable FPL. Since your expected annual earnings are over that amount, you are not eligible for the Essential Plan. Similarly, your earnings are 248.60% of the applicable FPL for Medicaid, and again, that is over the allowable limit.

It is also noted that on June 8, 2017 and June 29, 2017 you again updated your application.

On July 13, 2017, NYSOH issued a notice of eligibility determination based on annual expected earnings of $2,313.75. As noted above, your annual earnings for 2017 already equaled $4,586.25 by February 23, 2017; therefore, this figure cannot possibly be correct.

Since the record now contains more accurate information about your expected annual income, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of February 6, 2017, based on a one-person household, with an expected annual income of $29,981.25, [redacted] County.

Decision

The February 7, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of February 6, 2017, based on a one-person household, with an expected annual income of $29,981.25, residing in [redacted].

Effective Date of this Decision: July 24, 2017

How this Decision Affects Your Eligibility

Your eligibility as of February 7, 2017 is unchanged.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based on the income documentation you provided after the hearing.

If you are no longer working, you must update your NYSOH application with this information.

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

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 7, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of February 6, 2017, based on a one-person household, with an expected annual income of $29,981.25, residing in [redacted]

Your eligibility as of February 7, 2017 is unchanged.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance based on the income documentation you provided after the hearing.

If you are no longer working, you must update your NYSOH application with this information.

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.

□□□□□ (Bengali)

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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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)

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).

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).