



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

## Notice of Decision

Decision Date: July 05, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016968

[REDACTED]

Dear [REDACTED],

On June 29, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 10, 2017 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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## Decision

Decision Date: July 05, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000016968



## 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 your spouse, [REDACTED], was eligible to receive up to \$688.00 per month in advance payments of the premium tax credit, effective April 1, 2017?

Did NYSOH properly determine that your spouse was eligible for cost-sharing reductions?

Did NYSOH properly determine that your spouse was not eligible for the Essential Plan?

## Procedural History

On January 4, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to enroll in the Essential Plan with a \$20.00 monthly premium each for a limited time, effective February 1, 2017. Your coverage under the Essential Plan was conditional pending receipt of income documentation by April 3, 2017. You and your spouse enrolled in an Essential Plan on that same date, with such coverage beginning on February 1, 2017.

On February 28, 2017, NYSOH received (1) a pension benefit letter, dated December 2, 2016, issued to your spouse by the [REDACTED] reflecting [REDACTED] reduced pension benefit of \$893.75 per month, effective February 1, 2017, and (2) four earnings statements issued to your spouse by [REDACTED]

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current employer, [REDACTED] between January 20, 2017 and February 10, 2017.

On March 9, 2017, redetermined the eligibility of financial assistance for you and your spouse's.

On March 10, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to receive an advance premium tax credit (APTC) of up to \$688.00 and, if you enrolled in a silver level qualified health plan, eligible to receive cost-sharing reductions (CSR), effective April 1, 2017. That notice also stated that you and your spouse were not eligible for the Essential Plan because your income was over the allowable income limits for that programs.

On March 17, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were seeking for you and your spouse to be found eligible for coverage under the Essential Plan.

On June 29, 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 as opposed to your original desire to appeal on behalf of both yourself and your spouse, you were now seeking to just appeal your spouse's eligibility since you became enrolled in Medicare effective June 1, 2017.
- 2) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.
- 3) At the time of your January 3, 2017 application, you were seeking insurance for both yourself and your spouse. This election was duplicated in the redetermination of eligibility performed by NYSOH on March 9, 2017.
- 4) The redetermination of eligibility performed by NYSOH on March 9, 2017 listed an annual household income of \$35,992.19, consisting of \$893.75 per month your spouse receives from [REDACTED], and \$25,267.19 your spouse anticipates receiving from [REDACTED] current employer, [REDACTED] during 2017. You testified that these amounts were reasonably accurate.

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- 5) On February 28, 2017, you provided to NYSOH a pension benefit letter, dated December 2, 2016, issued to your spouse by the [REDACTED], reflecting [REDACTED] reduced pension benefit had been reduced from \$2,871.50 to \$893.75 per month, effective February 1, 2017.
- 6) On February 28, 2017, you provided to NYSOH four earnings statements issued to your spouse by [REDACTED] current employer, reflecting that [REDACTED] received (1) \$488.19 on January 20, 2017, (2) \$469.94 on January 27, 2017, (3) \$497.31 on February 3, 2017, and (4) \$488.19 on February 10, 2017.
- 7) Your application states that you will not be taking any deductions on your 2017 tax return.
- 8) You and your spouse live in [REDACTED], New York.
- 9) You testified that the health plans available through NYSOH were unaffordable, even after applying the tax credits available to you and your spouse. You were seeking for your spouse to be redetermined eligible for the Essential 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 \$16,020.00 for a two-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).

### 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 your spouse was eligible for an APTC of up to \$688.00 per month, effective April 1, 2017.

The redetermination of your spouse's eligibility by NYSOH, based on documentation you had submitted on February 28, 2017, was performed on March 9, 2017 and listed an annual household income of \$35,992.19, which was comprised of (1) \$10,725.00 (\$893.75 x 12 months) in your spouse's pension benefits and (2) \$25,267.19 (\$485.91 average weekly gross income x 52 weeks) in income from his current employer during 2017. The eligibility determination relied upon that information.

Your spouse is in a two-person household. You expect to file your 2017 income taxes as married filing jointly and will claim no dependents on that tax return.

Your spouse resides in [REDACTED], where the second lowest cost silver plan available for a couple through NYSOH costs \$907.13 per month.

An annual income of \$35,992.19 is 224.67% of the 2016 FPL for a two-person household. At 224.67% of the FPL, the expected contribution to the cost of the health insurance premium is 7.31% of income, or \$219.25 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 (\$907.13 per month) minus your expected contribution (\$219.25 per month), which equals \$687.87 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined your spouse to be eligible for up to \$688.00 per month in APTC, effective April 1, 2017.

The second issue is whether your spouse was properly found eligible for CSR, effective April 1, 2017.

CSR is available to a person who has a household income of greater than 250% of the FPL. Since a household income of \$35,992.19 is 224.67% of the applicable FPL, NYSOH correctly found your spouse to be eligible for CSR.

The third issue under review is whether NYSOH properly determined that your spouse was 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 \$35,992.19 is 224.67% of the 2016 FPL, NYSOH properly found your spouse to be ineligible for the Essential Plan.

Since the March 10, 2017 eligibility determination properly stated that, based on the information you provided, your spouse was eligible for and APTC of up to \$688.00 per month, eligible for CSR, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

Please note that this Decision has no effect of any subsequent eligibility determination issued by NYSOH after March 10, 2017.

## **Decision**

The March 10, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** July 05, 2017.

## **How this Decision Affects Your Eligibility**

Your spouse was eligible for an APTC of up to \$688.00 per month and, if your selected a silver-level plan, eligible for CSR, effective April 1, 2017.

Your spouse was ineligible for the Essential Plan.

Please note that this Decision has no effect of any subsequent eligibility determination issued by NYSOH after March 10, 2017.

## **If You Disagree with this Decision (Appeal Rights)**

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).



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

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- By fax: 1-855-900-5557

## **Summary**

The March 10, 2017 eligibility determination notice is AFFIRMED.

Your spouse was eligible for an APTC of up to \$688.00 per month and, if your selected a silver-level plan, eligible for CSR, effective April 1, 2017.

Your spouse was ineligible for the Essential Plan.

Please note that this Decision has no effect of any subsequent eligibility determination issued by NYSOH after March 10, 2017.

## **Legal Authority**

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

**A Copy of this Decision Has Been Provided To:**



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)

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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. y&b&tumi ama wo obi a okyerE 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.

## **שׂוֹדִיִּשׁ (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.

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