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

Notice of Decision

Decision Date: July 26, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017646

[redacted]

Dear [redacted]

On July 19, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 4, 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
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Decision

Decision Date: July 26, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000017646

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine that you were eligible for the Essential Plan, effective May 1, 2017?

Procedural History

On December 15, 2016, NY State of Health (NYSOH) issued an eligibility determination notice stating that you were eligible for up to $303.00 in advance payment for a premium tax credit (APTC) for a limited time and, if you enroll in a silver level qualified health plan, cost-sharing reductions, effective January 1, 2017. The notice requested that you submit income documentation by March 14, 2017 in order to confirm your eligibility.

Also on December 15, 2016, NYSOH issued an enrollment confirmation notice confirming your enrollment in a silver level qualified health plan as of January 1, 2017,

On April 3, 2017, NYSOH received your updated application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you were eligible for the Essential Plan with a $20.00 monthly premium, for a limited time, effective May 1, 2017.

Also on April 3, 2017, you spoke to NYSOH's Accounts Review Unit and appealed the eligibility determination insofar as you were found eligible for the

Essential Plan, and not eligible APTC. You also requested Aid to Continue while your appeal was pending.

On April 4, 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, for a limited time, effective May 1, 2017. This notice further directed you to submit income documentation by July 2, 2017.

Also on April 4, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan with a $20.00 monthly premium, effective May 1, 2017.

On April 8, 2017, NYSOH issued an eligibility determination stating that you were eligible for APTC with cost-sharing reductions for a limited time, effective May 1, 2017 because you had been granted Aid to Continue until a decision was made on your appeal.

On July 19, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was held open until August 3, 2017, to allow you time to submit supporting documentation.

On July 20, 2017, NYSOH Appeal's Unit received a three-page fax from you. The document was incorporated into the record as "Appellant's [redacted]", and the record was closed that same day.

Findings of Fact

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

1) You are seeking insurance for yourself.

2) 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.

3) The application that was submitted on April 3, 2017 listed annual household income of $23,050.00, consisting of $7,000.00 you earn from your employment and $16,050.60 you receive from Social Security Retirement. You testified that this amount was incorrect.

4) You testified that you work on commissions, and it is difficult to predict what you will exactly make for this year in sales.

5) You testified that you make a higher monthly commission toward the end of the year.

6) You testified that, while you cannot say for sure, you predict that you will make about the same amount in commissions as you did last year.

7) You testified, and provided documentation, that you made $10,604.00 in commissions for 2016.

8) You testified, and provided documentation, that you recently started receiving Social Security Retirement Benefits in April 2017, and that you make $1,783.00 a month in Social Security Retirement Benefits.

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

10) Your application states, and you confirmed, that you live in [redacted]

11) You testified that you would like to remain eligible for APTC because you would like to stay with the health plan that you were enrolled in on January 1, 2017.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

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 $11,800.00 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)).

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).

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)).

Legal Analysis

The issue is whether NYSOH properly determined that you were eligible to the Essential Plan, effective May 1, 2017.

The application that was submitted on April 3, 2017 listed an annual household income of $23,050.60, and the eligibility determination relied upon that information.

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.

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. According to your NYSOH account and, in part, your testimony, you meet the non-financial requirements to be eligible for the Essential Plan in that you are a New York State resident, not eligible to enroll in other coverage, under the age of 65, and not incarcerated.

In regards to the financial requirements, on the date of your application, the relevant FPL was $11,880.00 for a one-person household.

Since an annual household income of $23,050.60 is 194.02% of the 2016 FPL and you meet the non-financial requirements, NYSOH properly found you to be eligible for the Essential Plan, based on the information in your application.

An individual who is eligible to enroll in the Essential Plan is not eligible to receive advance premium tax credits because they are considered eligible for minimum essential coverage through the Marketplace. To be eligible for cost-sharing reductions, an individual must first be eligible to receive advance premium tax credits. Since you are not eligible to receive advance premium tax credits, you do not qualify to receive accost-sharing reductions either.

Therefore, the April 4, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for the Essential Plan, and ineligible for APTC and cost-sharing reductions, it is correct and is AFFIRMED.

However, on July 20, 2017, NYSOH’s Appeal’s Unit received your income documentation. The income documentation you submitted indicates that you make $1,783.00 a month in Social Security Retirement Benefits, and that this

benefit started in April 2017. You also submitted your 2016 1099 Form which indicates that you made $10,604.00 in income for 2016. You testified that you believe that this will be similar to the amount you make in 2017 in commissions. Therefore, your expected household annual income, based on the income documentation you submitted on July 20, 2017 and your testimony, is $26,651.00.

Since the record now contains a more accurate reflection of your annual income, your case is RETURNED to NYSOH to redetermine your eligibility based on a household of one person, residing in [redacted], with an annual expected income of $26,651.00, and to notify you accordingly.

Decision

The April 4, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a household of one person, residing in [redacted], with an annual expected income of $26,651.00, and to notify you accordingly.

Effective Date of this Decision: July 26, 2017

How this Decision Affects Your Eligibility

NYSOH properly determined that you were eligible for the Essential Plan, based on the information provided in your application.

Your case is being sent back to NYSOH to redetermine your eligibility based on the information your provided after the hearing..

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 April 4, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined that you were eligible for the Essential Plan, based on the information provided in your application.

Your case is RETURNED to NYSOH to redetermine your eligibility based on a household of one person, residing in [redacted], with an annual expected income of $26,651.00, and to notify you accordingly.

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]

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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.

□□□□□ (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 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)

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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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