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

Notice of Decision

Decision Date: September 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017945

[redacted]

Dear [redacted],

On August 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 11, 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: September 11, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017945

[redacted]

Issues

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

> Did NY State of Health properly determine you were eligible to receive up to $192.00 per month in advance payments of the premium tax credit, effective April 1, 2017?
>
> Did NY State of Health properly determine you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine you were not eligible for the Essential Plan?

Procedural History

On December 13, 2016, you submitted an updated application for financial assistance.

On December 14, 2016, NY State of Health (NYSOH) issued a notice of eligibility determination stating you were eligible to enroll in the Essential Plan, for a limited time, effective January 1, 2017. The notice directed you to submit proof of your income by March 13, 2017 to confirm the information in your application or you might lose your insurance or receive less help paying for your coverage.

Also on December 14, 2016, NYSOH issued an enrollment notice confirming your enrollment in an Essential Plan, effective January 1, 2017.

On March 11, 2017, NYSOH issued an eligibility determination notice, based on a March 10, 2017 systematic eligibility redetermination, stating you were eligible to receive up to $192.00 per month in advance payments of the premium tax credit (APTC), effective April 1, 2017. The notice also stated that you were eligible to receive cost-sharing reductions if you enrolled in a silver-level plan. The notice indicated that you were not eligible for the Essential Plan, because your household income was over the allowable limit for that program.

Also on March 11, 2017, NYSOH issued a disenrollment notice stating your enrollment in your Essential Plan would end on March 31, 2017, because you were no longer eligible to enroll in that plan.

On April 12, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were no longer eligible for the Essential Plan.

On April 14, 2017, NYSOH issued an eligibility determination notice, based on your grant of Aid to Continue, stating you were eligible for the Essential Plan, for a limited time, effective April 1, 2017, until a decision was made on your appeal. You subsequently reenrolled in an Essential Plan, effective April 1, 2017.

On August 17, 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 to August 31, 2017, to allow you to submit supporting documents.

As of August 31, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) You testified this appeal only involves your eligibility and not your child's.

2) You updated your application for the 2017 coverage year on December 13, 2016. That application listed your annual income as $28,080.00 consisting of $540.00 you earned weekly from your employment.

3) That application indicated you would file your 2017 tax return with a tax filing status of head of household and you would claim one dependent. You testified this information was accurate.

4) Your application indicated you reside in [redacted] and that you will not take any deductions on your 2017 tax return.

5) According to your account, NYSOH was unable to verify the income information listed in your application and you were determined conditionally eligible for the Essential Plan pending receipt of income documentation to verify your income.

6) On March 2, 2017, the following weekly paystubs were uploaded to your account:

   a. February 24, 2017 pay date in the gross amount of $676.50 for 41 hours at a pay rate of $16.50.

   b. February 17, 2017 pay date in the gross amount of $730.13 for 44.25 hours at a pay rate of $16.50.

   c. February 10, 2017 pay date in the gross amount of $585.75 for 35.50 hours at a pay rate of $16.50.

   d. February 3, 2017 pay date in the gross amount of $1,039.27 for 39 hours at a payrate of $16.50 including $77.50 in bonuses and $310.02 in commissions ([redacted]).

7) According to your account, on March 10, 2017, NYSOH verified your income documentation and increased your annual household income to $39,411.32 based on the $757.91 average weekly gross income amount from the four weekly paystubs you submitted.

8) NYSOH redetermined your eligibility, based on the recalculated annual income amount, and determined you eligible to receive $192.00 in monthly APTC, effective April 1, 2017.

9) You were disenrolled from your Essential Plan, effective March 31, 2017.

10) On March 28, 2017, you uploaded a letter from your employer stating you worked approximately 40 hours per week at a rate of $16.50 per hour.

11) You testified you are seeking eligibility to enroll in the Essential Plan.

12) You testified that you do not agree with NYSOH's redetermination of your annual income, because the paystubs you submitted were for a month in which you worked more hours than usual.

13) You also testified that the bonuses and commission included in your February 3, 2017 paycheck were not regular payments you received. You

testified that your employer sporadically holds events in which you can earn additional income, but it is not regularly occurring. You testified you can also earn commissions for selling specific products or setting up certain payment structures.

14) You testified that you are scheduled to work approximately 40 hours per week at a pay rate of $16.50 per hour. You further testified that due to a medical condition you are not always able to work your scheduled hours and that you have used up all your paid time off so you are no longer paid for days you take off.

15) You were directed to submit proof of your income for the last 30 days to support your claim that the February 2017 paystubs you submitted were not an accurate representation of your current income. NYSOH did not receive any additional income documentation.

16) You were granted Aid to Continue and reenrolled in an Essential Plan 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 $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).

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 $16,020.00 for a two-person household (81 Fed. Reg. 4036).

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 you were eligible for an APTC of up to $192.00 per month.

The updated application submitted on December 13, 2017 listed an annual household income of $28,080.00 consisting of $540.00 you earned weekly from your employment. However, according to your account, NYSOH was unable to verify that information and income documentation was requested. On March 2, 2017, you submitted four weekly paystubs for the month of February 2017 with an average gross weekly income of $757.91. One of your paystubs included an extra $387.52 in bonus and commission payments. NYSOH recalculated your annual income as $39,411.32, based on the average weekly gross income from the paystubs you submitted, and determined you eligible to receive up to 192.00 in monthly APTC. You appealed that determination.

You testified that you did not agree with NYSOH's redetermination of your annual income, because it was based on paystubs from a time in which you were working more hours than usual. You further testified that you only earn bonuses and commissions sporadically, so the February 2017 paystubs you submitted were not representative of your average monthly income. However, despite being directed to do so, you failed to submit any updated income documentation to support your contention that the February 2017 paystubs were not representative of your current income. Furthermore, it is noted that the letter you submitted from your employer, providing your pay rate and approximate weekly hours worked, does not account for any extra income you earn in the form of bonuses and commissions.

Based on your own testimony, it is concluded that the paystubs establishing what you actually earned is more reliable proof of your income than the employment letter omitting the extra income you testified to sporadically receiving. Thus, based on the evidence you submitted, and the lack of any documentation

establishing otherwise, NYSOH properly calculated your annual income as $39,411.32.

According to your application you are in a two-person household, because you expect to file your 2017 income taxes with a tax filing status of head of household and you will claim one dependent on that tax return.

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 $39,411.32 is 246.01% of the 2016 FPL for a two-person household. At 246.01% of the FPL, the expected contribution to the cost of the health insurance premium is 8.07% of income, or $265.04 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 ($265.04 per month), which equals $191.42 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you eligible for up to $191.00 per month in APTC.

The second issue is whether you were properly found eligible for cost-sharing reductions.

Cost-sharing reductions are available to applicants with a household income no greater than 250% of the FPL. Since a household income of $39,411.32 is 246.01% 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 you were not eligible for the Essential Plan, effective April 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 $39,411.32 is 246.01% of the 2016 FPL, NYSOH properly found you ineligible for the Essential Plan.

Since the March 11, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $192.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

Decision

The March 11, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 11, 2017

How this Decision Affects Your Eligibility

You remain eligible for up to $192.00 in APTC.

You are eligible for cost-sharing reductions.

You are 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:

- 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 March 11, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for up to $192.00 in APTC.

You are eligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

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.

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 नि:शुल्क 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).