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

Notice of Decision

Decision Date: September 25, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018943

[redacted]

[redacted],

On August 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 12, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: September 25, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018943

[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 and your spouse were eligible to receive up to $275.00 per month in advance payments of the premium tax credit (APTC), effective May 1, 2017?
>
> Did NYSOH properly determine that you and your spouse were not eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you and your spouse were not eligible for the Essential Plan?
>
> Did NYSOH properly determine that your children were eligible for Child Health Plus with a $45.00 per month premium, effective May 1, 2017?

Procedural History

On November 21, 2016, you submitted an application for financial assistance.

On November 23, 2016, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible for a limited time to receive up to $541.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective January 1, 2017. The notice also stated that your children were eligible for Child Health Plus for a limited time with a $15.00 per month premium, effective January 1, 2017. That notice further

directed you to submit income documentation for yourself by February 13, 2017, for your spouse by February 19, 2017, and for your children by January 20, 2017.

Also on November 23, 2016, NYSOH issued an enrollment confirmation notice stating that you and your spouse were enrolled in a qualified health plan, effective January 1, 2017, and your children were enrolled in Child Health Plus, effective January 1, 2017.

On December 5, 2016, you submitted income documentation.

On December 21, 2016, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application. You were directed to submit additional documentation. The due date was not extended.

On December 26, 2016, you submitted additional documentation.

On January 16, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application. You were directed to submit additional documentation for yourself by February 13, 2017, for your spouse by February 19, 2017, and for your children by February 4, 2017.

On January 18, 2017, you submitted additional documentation.

On January 26, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application. You were directed to submit additional documentation for yourself by April 29, 2017, and for your spouse and children by May 5, 2017.

On April 4, 2017, you submitted additional documentation.

On April 11, 2017, NYSOH validated your documentation and an application for health insurance was run on your behalf.

On April 12, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to receive up to $275.00 in APTC, and your children were eligible for Child Health Plus with $45.00 per month premium, effective May 1, 2017.

On May 15, 2017, you spoke to NYSOH's Account Review Unit and appealed the amount of financial assistance your family was found eligible for.

On May 18, 2017, NYSOH issued an eligibility determination notice, stating that you and your spouse were eligible for APTC and cost-sharing reductions for a limited time, and your children were eligible for a $15.00 Child Health Plus plan for a limited time, effective May 1, 2017, because your request for aid to continue had been granted until a decision is made on your appeal.

On August 23, 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 up to September 15, 2017, to allow you to submit supporting documents.

On September 14, 2017, you uploaded documentation into your NYSOH account and it was entered into the record as Appellant's Exhibit #1. The record remained open until September 15, 2017, and was closed that day.

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 married filing jointly. You will claim two dependents on that tax return.

2) You are seeking increased financial assistance with health insurance for yourself, your spouse, and your children.

3) The application that was submitted on April 11, 2017 listed annual household income of $79,023.00, consisting of $49,023.00 you earn from your employment and $30,000.00 your spouse earns from his employment. You testified that your spouse's income is correct, but yours is not.

4) You testified that you resigned from employment in May 2016, and are currently working part time for yourself. You testified that you earn about $1,500.00 per week or $78,000.00 annually before business expense deductions.

5) You testified that because of your change in employment status, your and your spouse's tax return for 2016 is not an accurate representation of your expected income in 2017.

6) Your application states that you will not be taking any deductions on your 2017 tax return. You testified that you may be taking business expense deductions.

7) On September 14, 2017, you uploaded two "[redacted]" Neither document contain the time period covered or a breakdown of income and expenses by month.

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

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 $24,300.00 for a four-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 $24,300.00 for a four-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)).

Child Health Plus

Child Health Plus (CHP) is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (*see* New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be "eligible for medical assistance"; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child's family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from $9.00 per month to $60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is $9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than $27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

The CHP premium is $15.00 per month for a child whose family household income is between 223% and 250% of the FPL, but no more than $45.00 per month per family (NY PHL § 2510(9)(d)(iii)).

The CHP premium is $30.00 per month for a child whose family household income is between 251% and 300% of the FPL, but no more than $90.00 per month per family (NY PHL § 2510(9)(d)(iv)).

The CHP premium is $45.00 per month for a child whose family household income is between 300% and 350% of the FPL, but no more than $135.00 per month per family (NY PHL § 2510(9)(d)(v)).

The CHP premium is $60.00 per month for a child whose family household income is between 351% and 400% of the FPL, but no more than $180.00 per month per family (NY PHL § 2510(9)(d)(vi)).

In an analysis of Child Health Plus 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 application, that was the 2016 FPL, which was $16,020.00 for a two-person household (80 Federal Register 3236, 3237).

Legal Analysis

The first issue is whether NYSOH properly determined that you and your spouse were eligible for an APTC of up to $275.00 per month.

The application that was submitted on April 11, 2017 listed an annual household income of $79,023.00 and the eligibility determination relied upon that information. Although you testified that the income listed is not correct, you did not provide sufficient documentation to recalculate your household’s expected annual income. The documentation you provided does not clearly state the time period covered or a breakdown by month, and therefore, cannot be used to reliably recalculate your household income. Therefore, NYSOH properly relied on an income of $79,023.00 to determine your eligibility.

You are in a four-person household. You expect to file your 2017 income taxes as married filing jointly and will claim two dependents on that tax return.

You reside in [redacted], where the second lowest cost silver plan available for a couple through NYSOH costs $912.91 per month.

An annual income of $79,023.00 is 325.2% of the 2016 FPL for a four-person household. At 325.2% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or $638.11 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 ($912.91 per month) minus your expected contribution ($638.11 per month), which equals $274.80 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to $275.00 per month in APTC.

The second issue is whether you and your spouse were properly found not eligible 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 $79,023.00 is 325.2% of the applicable FPL, NYSOH correctly found you and your spouse to be not eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you and your spouse were not eligible 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 $24,300.00 for a four-person household. Since an annual household income of $79,023.00 is 325.2% of the 2016 FPL, NYSOH properly found you and your spouse to be not eligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined your children to be eligible for Child Health Plus with a $45.00 monthly premium, effective May 1, 2017.

According to the record, you expect to file your 2017 tax return as married filing jointly and claim your children as dependents. Therefore, your children are also in in a four-person household. The application that was submitted on April 11, 2017 listed an annual household income of $79,023.00 and as noted above, the eligibility determination properly relied upon that information.

A child is eligible to enroll in Child Health Plus if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 301% and 350% of the FPL are responsible for a $45.00 per month Child Health Plus premium payment. On the date of your application, the relevant FPL was $24,300.00 for a four-person household. Since $79,023.00 is 325.2% of the 2016 FPL, NYSOH properly found your children to be eligible for Child Health Plus with a $45.00 per month premium payment.

Since the April 12, 2017 eligibility determination properly stated that, based on the information in the application, you and your spouse were eligible for up to $245.00 per month in APTC, not eligible for cost-sharing reductions, not eligible for the Essential Plan and your children were eligible for Child Health Plus with a $45.00 monthly premium, it is correct and is AFFIRMED.

Decision

The April 12, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 25, 2017

How this Decision Affects Your Eligibility

You and your spouse remain eligible for up to $275.00 in APTC.

You and your spouse are not eligible for cost-sharing reductions.

You and your spouse are not eligible for the Essential Plan.

Your children were properly determined eligible for Child Health Plus with a $45.00 per month premium.

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 12, 2017 eligibility determination notice is AFFIRMED.

You and your spouse remain eligible for up to $275.00 in APTC.

You and your spouse are not eligible for cost-sharing reductions.

You and your spouse are not eligible for the Essential Plan.

Your children were properly determined eligible for Child Health Plus with a $45.00 per month premium.

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)

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).

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।

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).

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