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

Notice of Decision

Decision Date: October 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018974

[redacted]

Dear [redacted],

On August 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 16, 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: October 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018974

[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 were not eligible for the Essential Plan?
>
> Did NYSOH properly determine you were eligible to receive up to $275.00 per month in advance payments of the premium tax credit, effective June 1, 2017?

Procedural History

On May 15, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating you were eligible to receive up to $275.00 in advance payments of the premium tax credit (APTC), and, if you enrolled in a silver level qualified health plan, eligible to receive cost-sharing reductions, both effective June 1, 2017.

Also on May 15, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as you were not eligible for the Essential Plan.

On May 16, 2017, NYSOH issued a notice of eligibility determination, based on your May 15, 2017 application, stating you were eligible to receive up to $275.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective June 1, 2017. That notice also stated

that you were not eligible for the Essential Plan, because your income was over the allowable income limits for that programs.

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 closed at the end of the hearing.

Findings of Fact

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

1) You were determined conditionally eligible for the Essential Plan, effective April 1, 2017, pending receipt of documentation verifying your income, based on a February 28, 2017 application listing your annual income as $22,791.60.

2) In April 2017, you submitted the following paystubs:

   a. March 2, 2017 biweekly paystub from [redacted]. in the gross amount of $862.10.

   b. March 16, 2017 biweekly paystub from [redacted]. in the gross amount of $818.41.

3) According to your account, NYSOH verified your income documentation on April 20, 2017 and recalculated your annual income from [redacted]., based on the average income in the paystubs submitted, and increased the amount from $18,174.00 to $21,846.63, for a total household income of $26,464.23, including the $4,617.60 amount of income from your second job as attested to in your previous application.

4) Based on the recalculated income amount, NYSOH determined you eligible to receive up to $297.00 in APTC, effective June 1, 2017.

5) You were disenrolled from your Essential Plan, effective May 31, 2017.

6) On May 9, 2017, NYSOH received an updated application submitted on your behalf listing your annual income as $26,236.60 consisting of $11.65 you earned per hour for 35 hours a week at [redacted] and $12.10 you earned per hour for 8 hours a week at your part time job. Based on that application, NYSOH determined you eligible to receive up to $300.00 in APTC, effective June 1, 2017.

7) On May 15, 2017, NYSOH received another updated application submitted on your behalf. That application increased your attested annual

income to $28,172.60 consisting of $21,203.00 earned annually from [redacted] and $580.80 earned monthly from your part time job.

8) NYSOH redetermined you eligible to receive up to $275.00 in APTC, effective June 1, 2017, based on your updated attested income amount.

9) You appealed insofar as you found ineligible for the Essential Plan.

10) You testified that the income information listed in your May 15, 2017 application was accurate for your [redacted] job at the time of the application. You testified that you earned $11.65 an hour and worked approximately 35 hours a week at that job.

11) You testified that for your part-time job you work every Saturday and earn $96.80 in gross income for that day. You testified that every other week you also work Sunday at your part time job and you earn $193.60 in gross income for the two days worked in that week.

12) You testified that you lost your job at [redacted] on May 16, 2017, after the May 15, 2017 application was filed. You testified that you received your last paycheck from that job at the end of May.

13) You testified that you began receiving unemployment insurance benefits in June 2017.

14) You testified that you have not updated your application to indicate that your income has decreased because you lost your full-time job.

15) You testified, and your applications indicate, you will not take any deductions on your 2017 tax return.

16) You testified, and your applications indicate, you will file your 2017 tax return with a tax filing status of single and you will claim no dependents.

17) You testified, and your applications indicate, you reside in [redacted].

18) You were granted aid to continue in your Essential Plan pending the decision in your appeal. You were reenrolled in an Essential Plan, effective June 1, 2017.

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).

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 $11,880.00 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)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were not eligible for the Essential Plan

The application submitted on May 15, 2017 attested to annual income of $28,172.60 consisting of $21,203.00 earned annually from [redacted]. and $580.80 earned monthly from your part time job. Although you testified that you earn more from your part time job than attested to in your application, that eligibility determination relied upon the income information in your May 15, 2017 application, so for the purposes of reviewing that determination as to your eligibility for the Essential Plan, the Appeals Unit will use the same information relied upon by NYSOH.

You are in a one-person household, because the evidence establishes you will file your 2017 tax return with a tax filing status of single and you will claim no dependents.

Pursuant to the regulations, 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 $11,880.00 for a one-person household. Since an annual household income of $28,172.60 is 237.14% of the 2016 FPL, over the 200% threshold, NYSOH properly found you to be ineligible for the Essential Plan, based on the information in your May 15, 2017 application.

The second issue under review is whether NYSOH properly determined you were eligible to receive up to $275.00 per month in advance payments of the premium tax credit, effective June 1, 2017.

As discussed, you confirmed the income information listed in your May 15, 2017 application was accurate, at that time, regarding your income from [redacted]. The application listed your annual income from that job as $21,203.00.

Although that application indicated you earned $580.80 monthly from your part-time job, or $6,969.60 annually, your testimony established that you earn more than that amount. You testified that for your part-time job you work every Saturday and earn $96.80 in gross income for that day. You testified that every other week you also work Sunday and you earn $193.60 in gross income for the two days worked that week. Accordingly, based on your testimony, you earn $7,550.40 annually at your part time job. Thus, the evidence establishes that at the time of your application, your total annual income was $28,753.40.

Since the record now establishes that the May 16, 2017 eligibility determination was based on inaccurate income information, that determination is not correct and must be RESCINDED.

Therefore, your case is returned to NYSOH to redetermine your eligibility as of May 15, 2017 for a one-person household with an annual income of $28,753.40.

It is noted that you testified that you lost your job at [redacted]. on May 16, 2017, after the May 15, 2017 application was filed. You testified that you received your last paycheck from that job at the end of May 2017. You further testified that you began receiving unemployment insurance benefits in June 2017. However, you testified, and the record reflects, you have not updated your application to indicate that your income has decreased because of losing your full-time job. Thus, you are reminded of your duty to report any changes in income to NYSOH with 30 days of the date of that change. A reduction in income may affect your eligibility for financial assistance with health insurance. Thus, you are encouraged to update your application immediately.

Decision

The May 16, 2017 eligibility determination is RESCINDED.

Your case is returned to NYSOH to redetermine your eligibility, as of May 15, 2017, for a one-person household with an annual income of $28,753.40.

Effective Date of this Decision: October 12, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility, as of May 15, 2017, based on the income information testified to during your hearing.

You will receive an updated eligibility determination from NYSOH.

You are encouraged to update your application immediately to report any changes in income since your last application on May 15, 2017, for an accurate eligibility determination going forward.

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

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).

Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The May 16, 2017 eligibility determination is RESCINDED.

Your case is returned to NYSOH to redetermine your eligibility, as of May 15, 2017, for a one-person household with an annual income of $28,753.40.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility, as of May 15, 2017, based on the income information testified to during your hearing.

You will receive an updated eligibility determination from NYSOH.

You are encouraged to update your application immediately to report and changes in income since your last application on May 15, 2017 for an accurate eligibility determination going forward.

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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