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

# Notice of Decision

Decision Date: October 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020006

[redacted]

Dear [redacted],

On September 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 27, 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: October 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020006

[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 $581.00 per month in advance payments of the premium tax credit (APTC), effective August 1, 2017?
>
> Did NYSOH properly determine that you and your spouse were eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you and your spouse were not eligible for the Essential Plan?

## Procedural History

On June 26, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you and your spouse were eligible to receive up to $581.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2017.

Also on June 26, 2017, you spoke to NYSOH's Account Review Unit and appealed, insofar as you and your spouse were not eligible for the Essential Plan. You also requested Aid to Continue, pending the outcome of your appeal.

On June 27, 2017, NYSOH issued a notice of eligibility determination, based on the June 26, 2017 application, stating that you and your spouse were eligible to

receive up to $581.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective August 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 limit for that program.

On June 29, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to enroll in the Essential Plan, for a limited time, with a $20.00 monthly premium each, effective August 1, 2017. This was because your request for Aid to Continue was granted, pending the outcome of your appeal.

Also on June 29, 2017, NYSOH issued a notice of enrollment confirmation, confirming you and your spouse's enrollment in an Essential Plan, beginning May 1, 2017. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On September 18, 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 through October 3, 2017, to allow you to submit supporting documents.

On September 20, 2017, you sent a three-page fax to the Appeals Unit. The record is now closed.

## 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 appealing on behalf of yourself and your spouse.

3) The application that was submitted on June 26, 2017 listed annual household income of $51,935.01, consisting of income your spouse earns from employment.

4) You testified that you were not sure if that amount is correct, and that you would submit your spouse's two most recent biweekly paystubs.

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

6) Your application states that you live in Washington County, and you testified that this is correct.

7) You testified that your spouse started his job in November 2016 and has not been offered health insurance yet

8) You testified that you and your spouse cannot afford the cost of enrolling in a qualified health plan, and that you want to remain in the Essential Plan.

9) After the hearing, you faxed a three-page document to NYSOH, consisting of a fax cover sheet and two biweekly paystubs for your spouse for the following pay dates and gross pay amounts:

    a. 8/31/2017: $1,755.25;
    b. 9/14/2017: $1,680.87, year-to-date of $32,818.60.

    Taken together, these documents are collectively marked and entered into the record as "Appellant's Exhibit One."

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

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 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 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).

## Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your spouse were eligible for an APTC of up to $581.00 per month.

The application that was submitted on June 26, 2017 listed an annual household income of $51,935.00, and the eligibility determination relied upon that information.

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 Washington County, where the second lowest cost silver plan available for a couple through NYSOH costs $880.63 per month.

An annual income of $51,935.00 is 213.72% of the 2016 FPL for a four-person household. At 213.72% of the FPL, the expected contribution to the cost of the health insurance premium is 6.92% of income, or $299.49 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 ($880.63 per month) minus your expected contribution ($299.49 per month), which equals $581.14 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to $581.00 per month in APTC, based on the information provided in your June 26, 2017 application.

The second issue under review is whether you and your spouse were properly found 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 $51,935.00 is 213.72% of the applicable FPL, NYSOH correctly found you and your spouse to be eligible for cost sharing reductions, based on the information in your June 26, 2017 application.

The third issue under review is whether NYSOH properly determined that you and your spouse were ineligible for the Essential Plan, as of your June 26, 2017 application.

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 $51,935.00 is 213.72% of the 2016 FPL, NYSOH properly found you and your spouse to be ineligible for the Essential Plan, based on the information in your June 26, 2017 application.

Since the June 27, 2017 eligibility determination properly stated that, based on the information you provided, you and your spouse were eligible for up to $581.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it was correct and is AFFIRMED.

However, after the hearing, you submitted two biweekly paystubs to NYSOH on behalf of your spouse (Appellant's Exhibit One). The average of those biweekly paystubs is $1,718.07. Therefore, your expected annual household income, based on this updated information, is $44,669.82 ($1,718.07 times 26 biweekly pay periods).

Since the record now contains more accurate income information, your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance, based on a four-person household with an expected annual income of $44,669.82, residing in Washington County.

## Decision

The June 27, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance, based on a four-person household with an expected annual income of $44,669.82, residing in Washington County.

NYSOH is directed to notify you of your new eligibility in writing.

**Effective Date of this Decision:** October 6, 2017

## How this Decision Affects Your Eligibility

You and your spouse were eligible for up to $581.00 per month in APTC, based on the information you provided in your June 26, 2017 application.

You and your spouse were eligible for cost-sharing reductions, based on the information in your June 26, 2017 application.

You and your spouse were ineligible for the Essential Plan, based on the information you provided in your June 26, 2017 application.

Your case is being sent back to NYSOH to redetermine you and your spouse's eligibility, based on the updated income information you provided after the hearing.

NYSOH will notify you of your updated eligibility in writing.

## 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 June 27, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance, based on a four-person household with an expected annual income of $44,669.82, residing in Washington County.

NYSOH is directed to notify you of your new eligibility in writing.

You and your spouse were eligible for up to $581.00 per month in APTC, based on the information you provided in your June 26, 2017 application.

You and your spouse were eligible for cost-sharing reductions, based on the information in your June 26, 2017 application.

You and your spouse were ineligible for the Essential Plan, based on the information you provided in your June 26, 2017 application.

Your case is being sent back to NYSOH to redetermine you and your spouse's eligibility, based on the updated income information you provided after the hearing.

NYSOH will notify you of your updated eligibility in writing.

## 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)**

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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