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

Notice of Decision

Decision Date: November 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020308

[redacted]

[redacted]

On October 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 6, 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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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).

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

Decision

Decision Date: November 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000020308

[redacted]

Issue

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

> Did NY State of Health properly determine you were eligible to receive up to $125.00 per month in advance payments of the premium tax credit, effective June 1, 2017?

Procedural History

On January 20, 2017, NY State of Health (NYSOH) received an initial application for financial assistance with health insurance submitted on your behalf.

On January 21, 2017, NYSOH issued a notice of eligibility determination stating you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, for a limited time, effective March 1, 2017. The notice directed you to submit proof of your income by April 20, 2017 or you might lose your insurance or receive less help paying for your coverage.

On February 1, 2017, NYSOH issued an enrollment notice confirming you were enrolled in an Essential Plan, effective March 1, 2017.

On May 5, 2017, NYSOH systematically redetermined your eligibility.

On May 6, 2017, NYSOH issued an eligibility determination stating you were eligible to receive advance premium tax credits (APTC) up to $125.00 per month, effective June 1, 2017. The notice indicated you were not eligible for Medicaid,

the Essential Plan, or to receive cost-sharing reductions, because your income was over the allowable income limit for those programs.

On July 6, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination insofar as you were not eligible for more financial assistance.

On October 12, 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 allow you to submit supporting documents. On October 26, 2017, NYSOH received the requested documentation which was incorporated into the record as Appellant's Exhibit 1. The record closed thereafter.

Findings of Fact

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

1) You testified, and your application indicates, you intend to file your 2017 tax return with a tax filing status of single and you will claim no dependents. You testified that information is accurate.

2) Your initial application, filed January 20, 2017, listed your annual expected income for 2017 as $20,840.00 consisting of the following annual income amounts from three separate employers:

    a. $7,928.00 from [redacted]

    b. $2,520.00 from the [redacted] from January 1, 2017 through May 31, 2017.

    c. $11,392.00 from the [redacted]

3) The January 20, 2017 application also identified other additional income of $1,000.00. You testified this was anticipated income you would make from [redacted].

4) The application indicated you would take a $2,000.00 student loan interest deduction in 2017. You testified that was accurate.

5) According to your account, NYSOH was unable to verify the income information in your application and you were directed to submit proof of your income.

6) On May 5, 2017, NYSOH received the following paystubs:

   a. Two biweekly paystubs from [redacted]:

      i. Pay date of April 14, 2017 in the gross amount of $242.00.

      ii. Pay date of April 28, 2017 in the gross amount of $660.00 with a year to date amount of $3,811.50.

   b. Two biweekly paystubs from [redacted]

      i. Pay date of April 26, 2017 in the gross amount of $153.69.

      ii. Pay date of May 10, 2017 in the gross amount of $252.00 with a year to date amount of $1,854.69.

   c. Two biweekly paystubs from [redacted]

      i. Pay date of April 13, 2017 in the gross amount of $671.01.

      ii. Pay date of April 27, 2017 in the gross amount of $747.25 with a year to date amount of $3,911.66.

7) According to your account, NYSOH verified your income documentation on May 5, 2017. NYSOH recalculated your income from [redacted] based on the average gross income in the paystubs submitted, and increased the annual income from that job from the $7,928.00 attested to in your prior application to $11,726.00.

8) NYSOH also calculated your annual income from the [redacted] paystubs as $16,422.74, purportedly based on the average gross income in the paystubs submitted.

9) Your account confirms that NYSOH added the annual income amount of $16,422.74, calculated from the [redacted] paystubs to the application as "other income." NYSOH added this income to the other three attested income sources in the application, increasing your total annual household income to $41,060.74, including the $2,000.00 student loan interest deduction and the $1,000.00 in attested "other income."

10) You testified the recalculated annual income amount was not accurate, because the income from the [redacted] paystubs was your income from the [redacted] and [redacted] had erroneously added that income as an additional income source.

11) You testified that you only had three employers in May 2017, and you provided full paystubs for each of those employers.

12) Based on the recalculated annual income amount, NYSOH determined you eligible to receive up to $125.00 in monthly APTC, effective June 1, 2017. You were no longer eligible for the Essential Plan and you were disenrolled, effective May 31, 2017.

13) You testified you are appealing that eligibility determination insofar as you were not eligible for more financial assistance.

14) According to your account, you have not been enrolled in health coverage since you were disenrolled from your Essential Plan, because, as you testified, paying qualified health plan premiums would create a "financial hardship."

15) You testified that in June 2017, your employment situation changed, because you began working as a [redacted]. You testified you currently have one client and you are paid biweekly in the gross amount of $2,566.00. You testified that you received your first check from that employment on July 14, 2017.

16) You testified that you stopped working at the [redacted] job and the [redacted] job at the end of May 2017 and you received your last paychecks from those jobs in June 2017. You testified that you still worked at [redacted] on an inconsistent basis, but expected to wrap up that employment by the end of the year.

17) You submitted the following documentation of your current income on October 26, 2017:

    a. A paystub from [redacted] with a check date of July 21, 2017 showing year to date earnings of $5,835.50.

    b. A spreadsheet detailing income received since June 30, 2017 from your [redacted] job.

    c. A bank statement showing final direct deposit payments received from NYS on June 22, 2017 and from the [redacted] on June 7, 2017 and a $4,400.00 deposit received on June 27, 2017 from "[redacted]

    d. A letter explaining that the paystub from [redacted] was the last paystub received and you only expect to work for them three to four more shifts and you anticipate your annual income from that job to

be $6,025.00. You also state that the $4,400.00 deposit was from you cashing out your 401K.

18) Your application indicates you reside 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 $11,880.00 for a one-person household (81 Federal Register 4036.).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution is between 8.21% and 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

Legal Analysis

The issue is whether NYSOH properly determined you were eligible to receive up to $125.00 per month in APTC, effective June 1, 2017.

You were determined conditionally eligible for the Essential Plan, effective March 1, 2017, based on a January 20, 2017 application listing your annual income for 2017 as $20,840.00. Your application identified three different employers, [redacted] Additionally, the application indicated that you would only earn income from the [redacted] job from January 1, 2017 through May 31, 2017. According to your account, [redacted] was unable to verify the income information listed in your application and you were directed to provide documentation of your income.

On May 5, 2017, NYSOH received two biweekly paystubs from each of your three employers. Your account confirms that NYSOH verified that income documentation and recalculated your income from [redacted] based on the average gross income in the paystubs submitted, and increased the annual income from that job from the $7,928.00 attested to in your prior application to $11,726.00. It is concluded that this was an accurate recalculation based on the documentation submitted. It appears NYSOH accepted the $2,520.00 annual income amount you attested to making from your job with the [redacted]

However, your account confirms that NYSOH miscalculated your annual income by adding the annual income amount of $16,422.74 it purportedly calculated based on the average gross income in the paystubs submitted from the [redacted] to the recalculated amount from [redacted] and the amounts attested to in your prior application for the [redacted] job and the [redacted] Thus, NYSOH calculated your annual income based on four different income sources. However, you credibly testified that you only had three income sources in May 2017. You testified that the paystubs from the [redacted] were from your job with the [redacted], and should not have been counted twice.

Since the evidence establishes that NYSOH miscalculated your annual income, based on the documentation submitted at that time, the resulting May 6, 2017 eligibility determination finding you eligible to receive up to $125.00 per month in

APTC, effective June 1, 2017, is not supported by the record and must be RESCINDED.

NYSOH properly calculated your annual income from [redacted] as $11,726.00, based on the documentation submitted on May 5, 2017. However, it is concluded that NYSOH miscalculated your annual income based on the average gross biweekly income in the paystubs submitted from the [redacted] $16,422.74. It is concluded that the gross biweekly income in those paystubs establishes an annual income of $18,437.38. Furthermore, your account confirms that NYSOH accepted the annual attested amount of $2,520.00 from your [redacted] Based on the information in your application that this job would end on May 31, 2017 and the year to date amount of $1,854.69 listed in your May 10, 2017 paystub from that job, it is concluded that the attested amount appears accurate. Thus, it is concluded that the proper calculation of your annual income as of May 5, 2017, based on the income documentation submitted at that time, was $32,683.38.

As such, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of May 5, 2017 based on an annual income of $32,683.38 and a household size of one.

Following the redetermination of your eligibility, you have the option of enrolling into a health plan, effective June 1, 2017, the date in which your plan could have become effective had the May 5, 2017 eligibility determination been correct. Alternatively, you can choose to enroll in a plan going forward. Be advised that you will be responsible for premium payments, if applicable, for any month in which you are enrolled into coverage.

The record confirms that you have not been enrolled in health coverage since your May 31, 2017 disenrollment from your Essential Plan. You testified that enrolling into a qualified health plan with the financial assistance you were determined eligible for pursuant to the May 5, 2017 eligibility determination would have created a “financial hardship.”

It is noted that sometimes after an appeal decision, an appellant can claim an exemption from the requirement to have health insurance. You might qualify for a health coverage exemption in 2017 if you did not have health coverage while you were waiting for an appeal decision about coverage eligibility or savings and your appeal was eventually successful.

You may wish to save this decision for reference when you file your tax return for 2017.

You must claim this exemption through the United States Department of Health and Human Services (HHS). Currently, NYSOH does not accept hardship exemption applications.

You will find the information you need to claim the exemption due to an appeal decision at https://www.healthcare.gov/exemptions-tool/#/results/2016/details/eligible-based-on-appeal. You can also call 1-800-318-2596.

Important: If you do not get a response from HHS to your exemption application in time to file your tax return, write the word "pending" in column "c" and file your return. If HHS does not approve your exemption, you will need to file an amended return later.

It is further noted that you testified, and submitted supporting documentation, that since the May 5, 2017 subject eligibility determination, your income and employment situation has changed. You testified that you no longer work for the [redacted] and you submitted documentation evidencing that you received your last paychecks for those jobs in June 2017. You further testified, and provided corroborating documentation, that in July 2017, you began working as a [redacted] earning income of $2,566.00 gross biweekly from a contract position. As a result, you were no longer working at [redacted] as much and expected to wrap up work at that position by the end of 2017. Thus, the evidence establishes that in 2018 you will earn $2,566.00 in gross income biweekly.

As such, your case is also RETURNED to NYSOH to determine your eligibility for financial assistance for 2018 with an annual income of $65,716.00, based on evidence of your income from your [redacted] and the information in your application indicating you earn additional income of $1,000.00 and take a $2,000.00 deduction for student loan interest. The record establishes your eligibility should be based on a one-person household.

Decision

The May 6, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of May 5, 2017 based on an annual income of $32,683.38 and a household size of one.

Following the redetermination of your eligibility, you have the option of enrolling into a health plan, effective June 1, 2017, the date in which your plan could have become effective had the May 5, 2017 eligibility determination been correct. Alternatively, you can choose to enroll in a plan going forward. Be advised that you will be responsible for premium payments, if applicable, in any month in which you are enrolled into coverage.

Your case is also RETURNED to NYSOH to determine your eligibility for financial assistance for 2018 based on an annual income of $65,716.00 and a one-person household.

Effective Date of this Decision: November 17, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

NYSOH will issue an updated determination of your eligibility for financial assistance, as of May 5, 2017, in accordance with this decision.

You will have the option of enrolling into a plan as early as June 1, 2017 or going forward.

You will be responsible for premium payments in any month in which you are enrolled into coverage.

You will also receive a determination of your eligibility for financial assistance for 2018 based on your testimony and the evidence submitted.

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 May 6, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance as of May 5, 2017 based on an annual income of $32,683.38 and a household size of one.

Your case is also RETURNED to NYSOH to determine your eligibility for financial assistance for 2018 based on an annual income of $65,716.00 and a one-person household.

This is not a final determination of your eligibility.

NYSOH will issue an updated determination of your eligibility for financial assistance, as of May 5, 2017, in accordance with this decision.

You will have the option of enrolling into a plan as early as June 1, 2017 or going forward.

You will be responsible for premium payments in any month in which you are enrolled into coverage.

You will also receive a determination of your eligibility for financial assistance for 2018 based on your testimony and the evidence submitted.

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).