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

Notice of Decision

Decision Date: October 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020334

[redacted]

Dear [redacted],

On September 26, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 18, 2017 eligibility determination notice.

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 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020334

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to $290.00 per month in advance payments of the premium tax credit (APTC), eligible for cost-sharing reductions (CSR), and ineligible for the Essential Plan, all effective August 1, 2017?

Procedural History

On March 29, 2017, you submitted an update to your application for financial assistance.

On March 30, 2017, NYSOH issued an eligibility determination notice based on the information contained in the March 29, 2017 application update. The notice stated that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium for a limited time, effective May 1, 2017. The notice requested that you provide proof of income by June 27, 2017 to confirm your eligibility.

Also on March 30, 2017, NYSOH issued an enrollment notice confirming your selection of an Essential Plan for your enrollment as of March 29, 2017, with coverage beginning May 1, 2017.

On June 12, 2017, NYSOH received 13 earnings statements issued to you by your employer, [redacted] between February 17, 2017 and June 9, 2017.

On June 16, 2017, NYSOH redetermined your eligibility.

On June 18, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive an APTC of up to $290.00 per month and, if you selected a silver-level plan for enrollment, eligible for CSR, effective August 1, 2017. That notice also stated that you were not eligible for the Essential Plan because your income was over the allowable income limit for that programs.

Also on June 18, 2017, NYSOH issued a disenrollment notice confirming that your Essential Plan coverage would end effective July 31, 2017.

On July 7, 2017, you spoke to NYSOH's Account Review Unit and appealed that you had been found eligible for APTC and CSR to purchase a plan through NYSOH, rather than being found eligible for the Essential Plan.

On September 26, 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 testified that you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking insurance for yourself only.

3) The application that you submitted on March 29, 2017 listed an annual household income of $18,200.00, based on weekly income of $350.00 from your employer, [redacted] In response to this application, NYSOH found you conditionally eligible for the Essential Plan, effective May 1, 2017. You were requested to provide additional income documentation to confirm your eligibility by June 27, 2017.

4) On June 12, 2017, you provided to NYSOH 13 earnings statements issued to you from [redacted] reflecting, in part, that you received in federal taxable gross income: (1) $408.66 on June 9, 2017, (2) $344.43 on June 2, 2017, (3) $508.28 on May 26, 2017, and (4) $684.17 on May 12, 2017. The May 12, 2017 and May 26, 2017 year-to-date income figures reflected that you received $719.24 in federal taxable gross income on or about May 19, 2017.

5) On June 16, 2017, NYSOH redetermined your eligibility based on a household income of $26,974.22, which was apparently based on the income documents you provided on June 12, 2017.

6) You testified, and your NYSOH application reflects, that you will not be taking any deductions on your 2017 tax return.

7) Your live in [redacted] New York.

8) You testified that you were seeking to remain eligible for the Essential Plan since the qualified health plan available through NYSOH, even after applying an APTC, were not affordable to you considering your other expenses.

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)).

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).

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).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Legal Analysis

The issue is whether NYSOH properly determined that you were eligible to receive an APTC of up to $290.00 per month; eligible for CSR; and, not eligible for the Essential Plan, effective August 1, 2017.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

You testified, and your NYSOH account reflects, that you live in [redacted], New York.

Based on the income documents that you submitted to NYSOH on June 12, 2017, NYSOH redetermined your eligibility based on a household income of $26,974.22. The eligibility determination relied upon that information.

You credibly testified that your earnings from your employer [redacted], and had provided income documents to NYSOH on June 12, 2017, at NYSOH's request. The earnings statements reflected that you received federal taxable gross income in the amount of: (1) $408.66 on June 9, 2017, (2) $344.43 on June 2, 2017, (3) $508.28 on May 26, 2017, and (4) $684.17 on May 12, 2017. The May 12, 2017 and May 26, 2017 year-to-date income figures reflected that you received $719.24 in federal taxable gross income on or about May 19, 2017.

It appears that upon reviewing your earnings over a four-week period to calculate your anticipated household income, the NYSOH representative calculated the total gross income you received between May 12, 2017 and June 9, 2017 ($2,074.94) and divided by four weeks to arrive at an average weekly income of $518.74, which over 52 weeks is a household income of $26,974.22. We find such a calculation on the part of NYSOH was incorrect.

The record reflects that not only did NYSOH calculate your income without extrapolating the income you received on May 19, 2017 by reviewing the available adjacent earnings statements, their calculation was based on the total gross income figure provided therein, rather than the federal taxable gross income.

Therefore, we find there is sufficient evidence that the June 18, 2017 eligibility determination notice is not supported by the credible evidence of record and must be RESCINDED.

Furthermore, your case is RETURNED to NYSOH to redetermine your eligibility based on an anticipated household income $25,747.93 in a one-person household in Queens County as of June 12, 2017.

Decision

The June 18, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to (1) redetermine your eligibility based on an anticipated household income $25,747.93 in a one-person household in Queens County as of June 12, 2017, and (2) facilitate your selection of a health plan once you receive a new determination reflecting your eligibility as of June 12, 2017.

Effective Date of this Decision: October 2, 2017

How this Decision Affects Your Eligibility

You will receive a new determination notice shortly reflecting your updated eligibility.

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 18, 2017 eligibility determination notice is RESCINDED.

Your case is being sent back to NYSOH to (1) redetermine your eligibility based on an anticipated household income $25,747.93 in a one-person household in Queens County as of June 12, 2017, and (2) facilitate your selection of a health plan once you receive a new determination reflecting your eligibility as of June 12, 2017.

You will receive a new determination notice shortly reflecting your updated eligibility.

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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