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: AP000000021004

[redacted]

[redacted]

On October 30, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 22, 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
Albany, NY 12211

Decision

Decision Date: November 17, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021004

[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, your spouse, and your son were eligible to receive up to $1,034.00 per month in advance payments of the premium tax credit (APTC), effective September 1, 2017?

Procedural History

On March 30, 2017, you submitted an updated application for financial assistance.

On March 31, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible for the Essential Plan for a limited time, effective May 1, 2017. The notice directed you to submit income documentation by June 28, 2017 to confirm the income information in your application.

Also on March 31, 2017, NYSOH issued a notice of enrollment confirmation, confirming you and your spouse's enrollment in an Essential Plan 1, beginning May 1, 2017.

On June 7, 2017, you updated your application and indicated that your son needed health insurance as well.

On June 8, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your son were eligible for the Essential Plan for a limited time, effective July 1, 2017. The notice directed you to submit income

documentation for yourself by June 28, 2017, and for your spouse and son by September 5, 2017, to confirm the income information in your application.

Also on June 8, 2017, NYSOH issued a notice of enrollment confirmation, confirming your family's enrollment in an Essential Plan 1, beginning May 1, 017 for you and your spouse, and July 1, 2017 for your son.

On June 27, 2017, you uploaded income documentation to your NYSOH account.

Also on June 27, 2017, NYSOH redetermined your household's eligibility.

On June 28, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your son were eligible to receive up to $1,002.00 per month in APTC, and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2017.

Also on June 28, 2017, NYSOH issued a disenrollment notice, stating that you, your spouse, and your son would be disenrolled from your Essential Plan coverage, effective July 31, 2017, because you were no longer eligible to enroll in the Essential Plan.

On July 21, 2017, you updated your NYSOH application.

On July 22, 2017, NYSOH issued a notice of eligibility determination stating that you, your spouse, and your son were eligible to receive up to $1,034.00 per month in APTC, and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, effective September 1, 2017.

On July 31, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination, 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 August 18, 2017, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible for the Essential Plan for a limited time, effective August 1, 2017. This was because your request for Aid to Continue was granted, pending the outcome of your appeal.

Also on August 18, 2017, NYSOH issued a notice of enrollment confirmation, confirming that you and your spouse were enrolled in an Essential Plan 1, beginning August 1, 2017. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On October 30, 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 November 14, 2017, to allow you to submit supporting documents.

As of November 15, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time 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 married filing jointly.

2) Your July 21, 2017 application states that you will claim one dependent on that tax return. During the hearing, you testified that you do not, in fact, think you will claim your son on your 2017 tax return, as he has been working and may file his own tax return.

3) You are seeking insurance for yourself and your spouse.

4) The application that was submitted on July 21, 2017 requested insurance for you and your spouse, as well as your son. You testified that he is in his last year of college [redacted], and that he has insurance through the school during the school year, so he only needed insurance over the summer.

5) The application that was submitted on July 21, 2017 listed annual household income of $43,875.00, consisting of $23,400.00 you earn from your employment $20,475.00 your spouse earns from his employment.

6) You testified that this amount was correct when you applied, but that your spouse's income recently decreased, as he is now working only three days a week, instead of four, as of October 28.

7) You testified that your spouse earns $12.50 an hour, and is now working 25 hours per week.

8) Your application states that you will not be taking any deductions on your 2017 tax return.

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

10) You testified that you would like you and your spouse to be eligible for the Essential Plan.

11) The record was held open for fifteen days after the hearing so that you could submit updated income documentation for yourself and your spouse. No documentation was submitted on your behalf.

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 $20,160.00 for a three-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 $20,160.00 for a three-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 issue under review is whether NYSOH properly determined that you, your spouse, and your son were eligible to receive up to $1,034.00 per month in APTC, effective September 1, 2017.

The application that was submitted on July 21, 2017 listed an annual household income of $43,875.00, and the eligibility determination relied upon that information.

The application also reflected that you were in a three-person household, and that you expected to file your 2017 income taxes as married filing jointly and to claim one dependent on that tax return.

However, during the hearing, you testified that you are filing this appeal on behalf of yourself and your spouse only, as your son is back in school and receives health insurance through his school. You also testified that you do not think that you will claim your son as a dependent on your 2017 tax return because he is working now. The July 21, 2017 application indicates that your son does not have any income.

During the hearing, you also testified that your spouse's income decreased as of October 28, 2017, as he went from working four days a week to three days a week. The record was kept open so that you could submit updated paystubs for yourself and your spouse; however, no documentation was submitted. Therefore, the record lacks a sufficient basis for changing the amount of income listed in your application.

As you have indicated that you are looking for insurance for yourself and your spouse only, and have indicated that you do not expect to claim your son on your 2017 income tax return and have not included his income on your application, the information on which the July 22, 2017 eligibility determination was based was not accurate. Therefore, the July 22, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance for 2017, based on a household of two with an expected annual income of $43,875.00 residing in [redacted]. NYSOH is directed to notify you in writing of your new eligibility.

You may update your application at any time regarding your income, household size, and tax filing information. Should you determine that you will, in fact, claim your son on your 2017 income tax return, you may update your NYSOH account to reflect this. You will be required to provide income information for your son, should you add him back into your tax household.

Decision

The July 22, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance for 2017, based on a household of two with an expected annual income of $43,875.00, residing in [redacted]

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

Effective Date of this Decision: November 17, 2017

How this Decision Affects Your Eligibility

The July 22, 2017 eligibility determination was based on inaccurate information, and is therefore being rescinded.

Your case is being sent back to NYSOH to redetermine you and your spouse's eligibility based on the updated information you provided in your testimony regarding your household size.

NYSOH will notify you in writing of your new eligibility.

You may update the information in your application at any time. Please note that, should you add your son back into your NYSOH household as a dependent, you will be required to provide income information on his behalf.

This decision is limited to your 2017 eligibility. You must update your application during open enrollment, which runs from November 1, 2017 to January 31, 2018 to find out your 2018 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

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 July 22, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance for 2017, based on a household of two with an expected annual income of $43,875.00, residing in [redacted].

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

The July 22, 2017 eligibility determination was based on inaccurate information, and is therefore being rescinded.

Your case is being sent back to NYSOH to redetermine you and your spouse's eligibility based on the updated information you provided in your testimony regarding your household size.

NYSOH will notify you in writing of your new eligibility.

You may update the information in your application at any time. Please note that, should you add your son back into your NYSOH household as a dependent, you will be required to provide income information on his behalf.

This decision is limited to your 2017 eligibility. You must update your application during open enrollment, which runs from November 1, 2017 to January 31, 2018 to find out your 2018 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)

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).