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

Notice of Decision

Decision Date: December 5, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000022507

On November 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 13, 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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STATE OF NEW YORK
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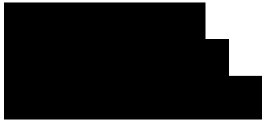

Issues

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 eligible to receive up to $249.00 per month in advance payments of the premium tax credit (APTC), effective October 1, 2017?
>
> Did NYSOH properly determine that you were eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan?

Procedural History

On June 1, 2017, you submitted an updated application for financial assistance.

On June 2, 2017, NYSOH issued a eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium per month for a limited time, effective June 30, 2017. The notice stated that you needed to submit proof of income by August 30, 2017.

Also on June 2, 2017, NYSOH issued a plan enrollment notice confirming that you were enrolled in an Essential Plan 1 with a $20.00 monthly premium, effective July 1, 2017.

On August 31, 2017, you submitted income documentation to NYSOH.

On September 1, 2017, the documentation you submitted on August 31, 2017 was reviewed by NYSOH and invalidated as it was unreadable.

On September 2, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application. The notice requested that you submit more proof of income by September 29, 2017.

On September 9, 2017, you submitted income documentation to NYSOH.

On September 12, 2017, that documentation was reviewed and verified by NYSOH. Your income was updated to $25,509.36 based on the documentation you submitted and your application for financial assistance was redetermined by NYSOH.

On September 13, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $249.00 per month in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective October 1, 2017. The notice further stated you no longer qualified for the Essential Plan as of September 30, 2017.

Also on September 13, 2017, NYSOH issued a disenrollment notice stating that the coverage in your Essential Plan 1 would end on September 30, 2017.

On September 18, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were found you eligible for APTC and not eligible for the Essential Plan.

On September 19, 2017, NYSOH, issued a plan enrollment notice stating that you were enrolled in a silver-level qualified health plan with a premium of $197.66 per month after the application of $249.00 of APTC and that the plan enrollment start date would be November 1, 2017.

On September 30, 2017, NYSOH issued an eligibility determination notice stating that you were granted Aid-to-Continue until a decision can be made on your appeal. That notice stated you were eligible for the Essential Plan with a $20.00 monthly premium, effective October 1, 2017, and you were re-enrolled in your Essential Plan 1 with a $20.00 monthly premium with a plan enrollment start date of October 1, 2017.

On November 13, 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 November 28, 2017, to allow you to submit supporting documents.

On November 27, 2017, NYSOH Appeals Unit received via secure facsimile your 11-page submission of your 2016 income tax return. On November 28, 2017, NYSOH Appeals Unit received your 11-page submission via secure facsimile

which was a duplicate of your November 27, 2017 submission. Those separate submissions were made part of the record as Appellant's Exhibit # 1 and Appellant's Exhibit # 2 respectively. The record was closed as of November 28, 2017.

Findings of Fact

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

1) According to your NYSOH account and your testimony, 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 health insurance for yourself.

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

4) The application that was submitted on June 1, 2017, listed annual household income of $23,000.00. Based on that application you were determined eligible for the Essential Plan for a limited period of time and were required to submit proof of your income by August 31, 2017.

5) On September 9, 2017, you submitted proof of income from the two sources of income which you listed on your June 1, 2017 application;

6) On September 12, 2017, NYSOH updated your income to $25,509.36 and re-ran your application for financial assistance based on this updated information.

7) You testified that your employment for both

8) You testified that your 2016 income tax return would be an accurate reflection of your income for 2017.

9) The 2016 income tax return you submitted reflects an adjusted gross income for 2016 of $25,240.00 (*see* Appellant's Exhibit # 1).

10) According to your NYSOH account and your testimony, you live in

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11) You testified that you want to be reconsidered eligible for the Essential Plan.

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 September 12, 2017 updated 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 in 2017 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)).

Essential Plan – Income Verification Process

For all individuals whose income is needed to calculate the household's eligibility, NYSOH must request data that will allow the NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i)). If NYSOH cannot verify the income information required to determine eligibility they must attempt to resolve the inconsistency including giving the applicant the opportunity to submit satisfactory documentary evidence (45 CFR §155.315(f); 42 CFR §600.345 (a)) See also New York's Basic Health Plan Blueprint, p. 17, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $249.00 per month.

The application that was submitted on June 1, 2017 listed an annual household income of $23,000.00. The June 2, 2017 eligibility determination notice stated that you were eligible for the Essential Plan for $20.00 monthly premium effective July 1, 2017 for a limited period of time. The notice stated that additional information was required in order to confirm your eligibility and you were requested to submit proof of income by August 30, 2017.

On September 9, 2017, you submitted additional proof from the two sources of income which you listed on your June 1, 2017 application; [redacted] and [redacted] On September 12, 2017, NYSOH reviewed and verified this income documentation and updated your income in your application to $25,509.36. On September 12, 2017, NYSOH re-ran your application for financial assistance based on this updated income information.

You testified that your employment with both [redacted] [redacted] part-time and that the hours of employment for each varies month to month. You testified that your 2016 income tax return would be reflective of your expected income for 2017. You submitted your 2016 income tax return and it reflected an adjusted gross income of $25,240.00. The difference between the updated 2017 income which NYSOH calculated on September 12, 2017 of

$25,509.36 and your 2016 income tax return adjusted gross income of $25,240.00 is $269.36. The amount of $269.36 is a reasonably insignificant and, as such, NYSOH's updated income of $25,509.36 used in the September 12, 2017 eligibility determination will not need to be disturbed.

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

You reside in [redacted], where the second lowest cost silver plan available for an individual through NYSOH costs $396.98 per month.

An annual income of $25,509.36 is 214.73% of the 2016 FPL for a one-person household. At 214.73% of the 2016 FPL, the expected contribution to the cost of the health insurance premium in 2017 is 6.96% of income, or $147.95 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 an individual in your county ($396.98 per month) minus your expected contribution ($147.95 per month), which equals $249.03 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $249.00 per month in APTC.

The second issue under review is whether you 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 $25,509.36 is 214.73% of the applicable 2016 FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan.

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 2016 FPL was $11,880.00 for a one-person household. Since an annual household income of $25,509.36 is 214.73% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the September 13, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to $249.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

Decision

The September 13, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: December 5, 2017

How this Decision Affects Your Eligibility

Effective October 1, 2017, you were eligible for up to $249.00 in APTC per month.

NYSOH properly found you eligible for cost-sharing reductions.

NYSOH properly found you ineligible for the Essential Plan.

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 September 13, 2017 eligibility determination notice is AFFIRMED.

Effective October 1, 2017, you were eligible for up to $249.00 in APTC per month.

NYSOH properly found you eligible for cost-sharing reductions.

NYSOH properly found you ineligible for the Essential Plan.

Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

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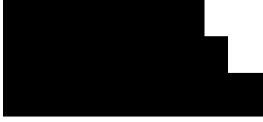
A Copy of this Decision Has Been Provided To:



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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)

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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.

(Urdu)اردو

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.

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