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

Notice of Decision

Decision Date: January 05, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023076

[redacted],

On December 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's September 12, 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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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: January 05, 2018

NY State of Health Account ID:
Appeal Identification Number: AP000000023076

Issue

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

> Did NY State of Health properly determine that you were eligible to receive up to $287.00 per month in advance payments of the premium tax credit and cost-sharing reductions, effective October 1, 2017?

Procedural History

On August 26, 2017, you submitted an application for financial assistance.

On August 27, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan for a limited time, effective October 1, 2017. This notice directed you to submit proof of your income by November 24, 2017, in order to confirm your eligibility for financial assistance.

Also on August 27, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in an Essential Plan with a plan enrollment start date of October 1, 2017.

On August 29, 2017, you updated your application for financial assistance.

On August 30, 2017, NYSOH issued a notice stating that the income information in your application did not match what NYSOH had received from state and federal data sources. This notice directed you to submit proof of your income by

September 13, 2017 in order for your eligibility for financial assistance to be determined.

Also on August 30, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Essential Plan would end as of October 1, 2017. This was because you were no longer eligible to enroll in the Essential Plan.

On September 7, 2017, you uploaded income documents to your NYSOH account.

On September 8, 2017, NYSOH verified the income documents you uploaded on September 7, 2017 and submitted an application on your behalf.

On September 9, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan, effective October 1, 2017.

On September 9, 2017, additional paystubs were uploaded to your NYSOH account.

On September 11, 2017, NYSOH reviewed the paystubs submitted on September 9, 2017 and recalculated your income. An application was submitted on your behalf based on this recalculated income.

On September 12, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $287.00 per month in advance payments of the premium tax credit (APTC) and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective October 1, 2017. That notice also stated that you were not eligible for the Essential Plan or Medicaid because your income was over the allowable income limits for those programs.

On October 3, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were no longer eligible for the Essential Plan.

On December 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 for fourteen days, to allow you to submit supporting documents.

On December 19, 2017, the Appeals Unit receive via fax copies of six of your paystubs. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. 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 single and you will not claim any dependents on that tax return.

2) You are seeking insurance for yourself. You testified that you are seeking to be found eligible for the Essential Plan or Medicaid.

3) The application that was submitted on August 26, 2017 listed annual household income of $22,070.00, consisting of $23,000.00 you expected to earn from your employment less $930.00 in student loan interest deductions. You testified that this amount was correct.

4) The application that was submitted on August 29, 2017 listed annual household income of $13,992.00, consisting of $14,922.00 you expected to earn from your employment less $930.00 in student loan interest deductions. This application indicated that you began working for [redacted] on February 28, 2017.

5) On September 7, 2017, you uploaded income documentation to your NYSOH account consisting of five paystubs from [redacted] the first is for pay date August 4, 2017 for a gross pay amount of $463.74; the second is for pay date August 11, 2017 for a gross pay amount of $542.91; the third is for pay date August 18, 2017 for a gross pay amount of $544.79; the fourth is for pay date August 25, 2017 for a gross pay amount of $416.06; the fifth is for pay date September 1, 2017 for a gross pay amount of $656.42.

6) On September 8, 2017, NYSOH recalculated your annual expected income to be $22,677.68 ($23,607.68 in wages less $930.00 in student loan interest deductions). That day, NYSOH updated the income in your application to reflect gross earnings of $23,607.68, for the entire year of 2017. The indication that you began working for [redacted] on February 28, 2017 was removed.

7) On September 9, 2017, additional paystubs were uploaded to your NYSOH account, which consisted of paystubs you faxed to NYSOH on September 7, 2017. This submission consisted of six paystubs, the five previously submitted paystubs as well as the paystub from pay date July 28, 2017 for a gross pay amount of $375.78.

8) On September 11, 2017, NYSOH recalculated your annual expected income to be $25,947.50 ($26,877.50 less $930.00 in student loan interest deductions).

9) You testified that in 2017 you have worked for two employers. You explained that you worked for [redacted] until February 2017 from which you made approximately $600.00. You then began working for [redacted] on February 27, 2017 or February 28, 2017. You further testified that you did not collect unemployment benefits in 2017.

10) Your application states, and you confirmed, that you will be taking a deduction for student loan interest on your 2017 tax return.

11) You submitted paystubs that show that in August 2017 you earned $1,967.50. You testified that this amount was correct and you had no other income for August 2017.

12) You testified that your only income in September 2017 was wages from employment.

13) Following the hearing, you submitted six paystubs; the first is for pay date September 8, 2017 for a gross pay amount of $456.90; the second is for pay date September 15, 2017 for a gross pay amount of $436.20; the third is for pay date September 22, 2017 for a gross pay amount of $580.31; the fourth is for pay date September 29, 2017 for a gross pay amount of $484.40; the fifth is for pay date October 6, 2017 for a gross pay amount of $503.73; the sixth is for the pay period from December 3, 2017 to December 9, 2017 and pay date December 16, 2017 for a gross pay amount of $437.70 and gross year to date earnings of $19,336.87.

14) You testified that you believe that the September 12, 2017 eligibility determination notice was incorrect because you believe your income was miscalculated. You further testified that the September 1, 2017 pay was uncharacteristically high due to special training that you underwent during that pay period.

15) Your application states that you live in Rensselaer County.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

<u>Advance Payments of Premium Tax Credit</u>

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 Fed. Reg. 4036.).

For annual household income in the range of at least 200% but less than 250% of the 2017 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 (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)).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the

applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

Legal Analysis

The issue is whether NYSOH properly determined that you were eligible for APTC of up to $287.00 per month and cost sharing reductions, effective October 1, 2017.

You expect to file your 2017 income taxes as single and will not claim any dependents on that tax return. Therefore, you are in a one-person household.

The application that you submitted on August 29, 2017 listed annual household income of $13,992.00. Following submission of this application, NYSOH requested that you submit documentation of your household income.

On September 7, 2017, you uploaded five paystubs from your employer.

On September 8, 2017, NYSOH verified your paystubs as satisfactory documentation of your income and an application for financial assistance was run on your behalf by an NYSOH representative. The NYSOH representative entered into your application earned income of $23,607.68 less student loan interest deductions of $930.00 for an annual expected income of $22,677.68. The NYSOH representative deleted your indication that you began working for [redacted] on February 28, 2017.

On September 9, 2017, additional paystubs, which you had faxed to NYSOH on September 7, 2017, were uploaded to your NYSOH account.

On September 11, 2017, NYSOH verified these paystubs as satisfactory documentation of your income and an application for financial assistance was run on your behalf by an NYSOH representative. The NYSOH representative entered into your application earned income of $26,877.50 less student loan interest deductions of $930.00 for an annual expected income of $25,947.50.

It is unclear from the record how NYSOH calculated your annual earned income to be $23,607.68. Furthermore, it is unclear how NYSOH calculated your annual earned income to be $26,877.50, however, the record reflects the only way the paystubs you submitted could generate an earned income of $26,877.50 would be if you worked for this employer for 52 weeks rather than the 44 weeks you indicated in both your application and in your testimony.

Therefore, the income amount that was relied upon in the September 12, 2017 eligibility determination notice is not supported by the record and the eligibility determination is RESCINDED.

Following the hearing, you submitted additional income documentation.

Therefore, your case is RETURNED to NYSOH to redetermine your eligibility as of September 11, 2017, based on a one-person household, residing in Rensselaer County, with an expected annual household income of $20,421.76 (as your year to date total as of December 16, 2017 of $19,336.87 divided by 41 weeks multiplied by 44 weeks worked for a total of $20,751.76 plus $600.00 you earned from your previous employment as per your credible testimony, less student loan interest deductions of $930.00).

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted paystubs that show in August 2017 you received $1,967.50 and in September 2017 you received $2,614.63.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,387.00 per month. Since the documentation you provided shows that you in earned $1,967.50 in August 2017 and $2,614.63 in September 2017, the months in which you submitted applications, the NYSOH Appeals Unit declines to return to your case to NYSOH to redetermine your eligibility for financial assistance on the basis of monthly income.

Decision

The September 12, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of September 11, 2017, based on a one-person household, residing in Rensselaer County, with an expected annual household income of $20,421.76.

Effective Date of this Decision: January 05, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance with health insurance based on information you provided during the hearing.

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 12, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility as of September 11, 2017, based on a one-person household, residing in Rensselaer County, with an expected annual household income of $20,421.76.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility for financial assistance with health insurance based on information you provided during the hearing.

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)

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.

(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.

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).