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

Notice of Decision

Decision Date: January 09, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023445

[redacted]

Dear [redacted]

On December 7, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 29, 2017 eligibility determination and October 18, 2017 plan enrollment 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: January 09, 2018

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000023445

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

> Did NY State of Health properly determine that you were eligible to receive up to $230.00 per month in advance payments of the premium tax credit, effective October 1, 2017?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were not eligible for the Essential Plan?
>
> Did NY State of Health properly determine enrollment in your Essential Plan 2 was effective December 1, 2017?

Procedural History

On September 13, 2016, NYSOH issued an eligibility determination notice stating you were eligible for Medicaid, effective September 1, 2016. You enrolled in a Medicaid Managed Care plan, effective October 1, 2016.

On July 2, 2017, NYSOH issued a notice that it was time to renew your health insurance for the upcoming coverage year. That notice stated that based on information from federal and state sources, NYSOH could not make a decision about whether you would qualify for financial help paying for your health

coverage, and that you needed to update your account by August 15, 2017 or you might lose the financial assistance you were currently receiving.

No updates were received by August 15, 2017 and NYSOH redetermined your eligibility for financial assistance with health insurance.

On August 17, 2017, NYSOH issued a notice stating you were not eligible for health insurance through NYSOH because you did not respond to the renewal notice. The effective date of this determination was September 1, 2017.

On August 17, 2017, NYSOH issued a disenrollment notice terminating your enrollment in your Medicaid Managed Care plan, effective August 31, 2017.

On August 28, 2017, NYSOH received your updated application for financial assistance.

On August 29, 2017, NYSOH issued a notice of eligibility determination stating you were eligible for advance payments of the premium tax credit up to $230.00 per month, as well as cost-sharing reductions if you enrolled in a silver level qualified health plan, effective October 1, 2017. The notice stated you must select your plan by October 30, 2017.

On August 29, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a silver-level qualified health plan on August 28, 2017, with an enrollment start date of September 1, 2017.

On October 17, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared finding you eligible to enroll in the Essential Plan with a $0.00 per month premium for a limited time, effective December 1, 2017.

You also enrolled in an Essential Plan with a start date of December 1, 2017.

Also on October 17, 2017, you spoke to NYSOH’s Account Review Unit and appealed the start date of your Essential Plan.

On October 18, 2017, NYSOH issued an eligibility determination notice stating you were eligible to enroll in the Essential Plan for a limited time for a cost of $0.00 per month, effective December 1, 2017. The notice directed you to provide proof of your income by January 15, 2018.

Also on October 18, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan 2, effective December 1, 2017.

Also on October 18, 2017, NYSOH issued a disenrollment notice stating your silver-level qualified health plan would end November 30, 2017, because you were no longer eligible to enroll in that plan.

On December 4, 2017, you faxed copies of your income documentation (*see* Document [redacted]).

On December 6, 2017, NYSOH issued an eligibility determination notice stating you were fully eligible to enroll in the Essential Plan for a cost of $0.00 per month, effective January 1, 2018.

On December 6, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan 2, effective December 1, 2017.

On December 7, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing 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 health insurance for yourself.

3) The application that was submitted on August 28, 2017, listed an annual household income of $27,040.00, consisting of income you earn from your employment. The income consisted of $13.00 an hour for forty hours a week at one employer. You testified that this amount was not correct, that you believe you make less as you are only a seasonal employee.

4) According to your NYSOH account, you submitted your application over the telephone with a NYSOH representative on August 28, 2017. You testified this was correct.

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

6) You enrolled in a silver-level qualified health plan effective September 1, 2017.

7) You provided copies of your paystubs to NYSOH for a four-week period with pay dates of November 17, and December 1, 2017. The paystubs

were in the gross amounts of $720.00 and $760.00 respectively (*see* Document [redacted]).

8) The application submitted on October 17, 2017, stated you had an annual household income of $17,800.00.

9) According to your NYSOH account and your testimony, you enrolled in an Essential Plan 2 for a cost of $0.00 per month on October 17, 2017. The enrollment start date was December 1, 2017.

10) You testified that you wanted your enrollment in an Essential Plan to begin on November 1, 2017 because you did not pay your premium to your qualified health plan for the month of November 2017.

11) NYSOH records do not indicate that you have been disenrolled from your qualified health plan for non-payment of premium.

12) Your application states that you live in Erie County, New York.

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 200% but less than 250% of the 2017 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 Effective Date

For individuals seeking enrollment in an Essential Plan, New York State has elected to follow the same rules that NYSOH uses in determining effective dates for individuals seeking enrollment in qualified health plans (NY Social Services Law § 369-gg(4)(c); New York's Basic Health Plan Blueprint, p. 16, as approved January 2016; *see* https://www.medicaid.gov/basic-health-program/basic-health-program.html).

The effective date of coverage by an Essential Plan is determined by the date on which an applicant selects a plan for enrollment. For individuals who are eligible for enrollment, NYSOH must generally ensure that coverage is effective the first day of the following month for selections received by NYSOH from the first to the fifteenth of any month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(i); *see also* 42 CFR § 600.320). For selections received by NYSOH from the sixteenth to the last day of any month, NYSOH must ensure coverage is effective the first day of the second following month (45 CFR §§ 155.410(f)(2), 155.420(b)(1)(ii)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $230.00 per month.

The application that was submitted on August 28, 2017, listed an annual household income of $27,040.00 and the eligibility determination relied upon that information.

You are in a one-person household for purposes of the following 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 Erie County, where the second lowest cost silver plan available for an individual through NYSOH costs $396.98 per month.

An annual income of $27,040.00 is 227.61% of the 2016 FPL for a one-person household. At 227.61% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 7.41% of income, or $166.97 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 ($166.97 per month), which equals $230.01 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $230.00 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 $27,040.00 is 227.61% of the applicable 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 eligible 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 FPL was $11,880.00 for a one-person household. Since an annual household income of $27,040.00 is 227.61% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the August 29, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $230.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

The fourth issue under review is whether NYSOH properly determined that your enrollment in the Essential Plan 2 was effective December 1, 2017.

You testified, and the record indicates, that you updated your NYSOH application on October 17, 2017. As a result, you were found eligible for the Essential Plan as of December 1, 2017, and enrolled into a plan that day for a December 1, 2017 start date.

The date on which enrollment in an Essential Plan can take effect depends on the day a person selects the plan for enrollment.

A plan that is selected from the first day to and including the fifteenth day of a month goes into effect on the first day of the following month. A plan that is selected from the sixteenth day of the month to the end of the month goes into effect on the first day of the second following month.

Since, on October 17, 2017, you selected an Essential Plan, your enrollment properly took effect on the first day of the second month following October 2017; that is, on December 1, 2017.

Therefore, the October 18, 2017 plan enrollment notice stating that your enrollment in the Essential Plan 2 was effective December 1, 2017, is correct and must be AFFIRMED.

Decision

The August 29, 2017 eligibility determination notice is AFFIRMED.

The October 18, 2017 plan enrollment notice is AFFIRMED.

Effective Date of this Decision: January 09, 2018

How this Decision Affects Your Eligibility

You were eligible for APTC up to $230.00 per month, effective October 1, 2017.

You were eligible for cost-sharing reductions, effective October 1, 2017.

You were ineligible for the Essential Plan, effective October 1, 2017

However, on October 17, 2017, you were redetermined eligible for the Essential Plan, effective December 1, 2017.

Your enrollment in the Essential Plan 2 was effective December 1, 2017.

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 August 29, 2017 eligibility determination notice is AFFIRMED.

The October 18, 2017 plan enrollment notice is AFFIRMED.

You were eligible for APTC up to $230.00 per month, effective October 1, 2017.

You were eligible for cost-sharing reductions, effective October 1, 2017.

You were ineligible for the Essential Plan, effective October 1, 2017

However, on October 17, 2017, you were redetermined eligible for the Essential Plan, effective December 1, 2017.

Your enrollment in the Essential Plan 2 was effective December 1, 2017.

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 तपाईलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईले बोल्ने भाषामा तपाईलाई 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.

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