



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

Notice of Decision

Decision Date: January 12, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023809

[REDACTED]

[REDACTED]

On December 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 26, 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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Decision

Decision Date: January 12, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000023809



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 \$130.00 per month in advance payments of the premium tax credit, effective December 1, 2017?

Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?

Did NY State of Health properly determine that you were not eligible for the Essential Plan?

Procedural History

On October 16, 2017, NY State of Health (NYSOH) received your application for financial assistance with health insurance.

On October 17, 2017, NYSOH issued an eligibility determination notice stating that, for a limited time, you were eligible to receive up to \$255.00 per month in advanced premium tax credits (APTC) and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan, effective December 1, 2017. This notice also directed you to submit proof of income by January 14, 2018, to confirm your eligibility.

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On October 21, 2017, you faxed a five-page document containing the requested income documentation; which was uploaded to your account on October 25, 2017.

Also on October 25, 2017, NYSOH validated the income documentation, updated the income listed in your application, and submitted a new application on your behalf.

On October 26, 2017, NYSOH issued an eligibility determination stating that you were eligible for up to \$130.00 per month in APTC, effective December 1, 2017.

On October 30, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not eligible for the Essential Plan.

On November 3, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan with a \$20.00 monthly premium, for a limited time, effective December 1, 2017. This notice stated that you had been granted Aid to Continue until a decision is made on your appeal.

Also on November 3, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan with a \$20.00 monthly premium, effective December 1, 2017.

On December 21, 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 until January 5, 2017, to allow you time to submit supporting income documentation.

As of January 5, 2017, the NYSOH's 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 single, and 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 October 16, 2017, listed an expected annual household income of \$24,480.00, consisting of income you earn from your employment.
- 5) On October 21, 2017, you faxed a five-page document to NYSOH, which included four weekly paystubs.
- 6) On October 25, 2017, the income documentation was validated and the NYSOH representative changed your expected annual household income from \$24,480.00 to \$33,866.89. You testified you are unsure as to whether this amount is correct.
- 7) You testified that your employment depends on the weather and you usually only work from April to December every year.
- 8) You testified that you receive a flat rate for your prevailing wages but, if you get contracted out to do work, you make a higher hourly wage while doing that job. As a result, you testified that your income is inconsistent.
- 9) According to your application and testimony, you live in Monroe 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

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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 250% but less than 300% of the 2016 FPL, the expected contribution for 2017 is between 8.21% and 9.69% 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

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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)).

Verification Process

For all individuals, whose income is needed to calculate the household's eligibility, NYSOH must request data from state and federal data sources that will allow NYSOH to verify the household's income (45 CFR §155.320(c)(1)(i), 42 CFR § 435.945).

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 § 435.952).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to \$130.00 per month.

For all individuals whose income is needed to calculate the applicant's eligibility for financial assistance, NYSOH must request data that will allow NYSOH to verify the household's income. If NYSOH cannot verify the income information

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listed in the application required to determine the applicant's eligibility, they must attempt to resolve the inconsistency, which includes giving the applicant the opportunity to submit satisfactory documentary evidence.

The application that was submitted on October 16, 2017 listed an annual household income of \$24,480.00. The income information that was entered into this application did not match what NYSOH received from federal and state data sources. As a result, NYSOH issued an eligibility determination notice stating that you were eligible for up to \$255.00 per month in APTC and cost-sharing reductions, for a limited time, and directed you to submit income documentation to confirm your eligibility.

On October 21, 2017, you faxed a five-page document to NYSOH which contained the requested income documentation. On October 25, 2017, NYSOH validated the income documentation and updated your expected annual income from \$24,480.00 to \$33,866.89. You testified that you are unsure as to whether this amount is correct.

As a result, the Hearing Officer left the record open until January 5, 2017 to allow you time to submit additional income documentation so as to have a more accurate reflection of your current expected annual income. However, by January 5, 2017, the NYSOH's Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, NYSOH must rely upon the record as developed at the time of the hearing for this Decision.

NYSOH calculated your expected annual income to be \$33,866.89 based on the income documentation you faxed on October 21, 2017 and the eligibility determination relied upon that information.

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 Monroe County, where the second lowest cost silver level qualified health plan available for an individual through NYSOH for 2017 costs \$390.79 per month.

An annual income of \$33,866.89 is 285.07% of the 2016 FPL for a one-person household. At 285.07% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 9.25% of income, or \$261.06 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 (\$390.79 per month) minus your expected contribution (\$261.06 per month), which equals \$129.73 per month. Therefore, rounding to the nearest

dollar, NYSOH correctly determined you to be eligible for up to \$130.00 per month in APTC.

The second issue under review is whether you were properly found you to be ineligible 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 \$33,866.69 is 285.07% of the applicable FPL, NYSOH correctly found you to be ineligible 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 FPL was \$11,880.00 for a one-person household. Since an annual household income of \$33,866.69 is 285.07% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the October 26, 2017 eligibility determination notice properly stated that you were eligible for up to \$130.00 per month in APTC, ineligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

Decision

The October 26, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 12, 2018

How this Decision Affects Your Eligibility

NYSOH properly determined that you were eligible for up to \$130.00 per month in APTC in 2017.

NYSOH properly determined that you were ineligible for cost-sharing reductions.

NYSOH properly determined that you were 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

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 26, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined that you were eligible for up to \$130.00 per month in APTC in 2017.

NYSOH properly determined that you were ineligible for cost-sharing reductions.

NYSOH properly determined that you were ineligible for the Essential Plan.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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।

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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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye b&etumi ama wo obi a okyer& 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 کرم 1-855-355-5777 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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