STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: February 06, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024282

On January 5, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 17, 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
  PO 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(b).

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: February 06, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024282

Issue

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

> Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to $327.00 per month in advance payments of the premium tax credit (APTC) and eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan (QHP), effective November 1, 2017?

Procedural History

On October 15, 2017, you uploaded income documentation to your NYSOH account.

On October 16, 2017, you updated your NYSOH application for financial assistance. That day, NYSOH prepared a preliminary eligibility determination stating that you were eligible for Medicaid, effective October 1, 2017. You selected a Medicaid Managed Care plan for enrollment that same day.

Also on October 16, 2017, NYSOH reviewed the income documentation you submitted and redetermined your eligibility.

On October 17, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $327.00 per month in APTC, and eligible for cost-sharing reductions if you enrolled in a silver-level QHP, effective November 1, 2017.

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On November 13, 2017, you spoke to NYSOH's Account Review Unit and appealed, insofar as you were not eligible for a higher level of financial assistance.

On January 5, 2018, 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 22, 2018, to allow you to submit supporting documents.

On January 16, 2018, you uploaded documentation to your NYSOH account. 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. You will claim no dependents on that tax return.

2) On October 15, 2017, you uploaded four weekly paystubs to your account for the following dates and gross earnings:

    a. September 21, 2017: $130.88 ( );
    b. September 28, 2017: $263.18 (
    c. October 5, 2017: $234.90);
    d. October 12, 2017: $27.10, with year-to-date earnings of $15,107.00 (

3) After you uploaded this documentation, NYSOH reviewed it and determined that your annual expected income for 2017 was $23,920.00.

4) You testified that you were not sure if that figure was correct, but that you believe that you should be eligible for the Essential Plan if it is correct.

5) The record was left open for fifteen days after the hearing so that you could submit your last paystub for 2017.

6) After the hearing, you uploaded one paystub; however, this paystub is dated January 4, 2018 and, as such, does not contain your 2017 year-to-date total ( ).

7) Your application states that you will not be taking any deductions on your 2017 tax return, and you confirmed this in your testimony.

8) Your application states that you live in Kings County.

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

Applicable Law and Regulations

Advance Payments of Premium Tax Credit

APTC are generally available to a person who is eligible to enroll in a 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 NYSOH 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), IRS Revenue Procedure (RP) 2016-24).

In an analysis of APTC eligibility, the determination is based on the applicable 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 2016 FPL, the expected contribution is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3, IRS RP 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 federal income tax return). Those

who take less tax credit in advance than they can claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

Cost-Sharing Reductions

Cost-sharing reductions are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable 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 Federal Register 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, as approved January 2016; *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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, *see* www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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 Federal Register 8831, 8832).

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 under review is whether NYSOH properly determined that you were eligible to receive up to $327.00 per month in APTC, and eligible for cost-sharing reductions, effective November 1, 2017.

You uploaded income documentation to your account on October 15, 2017. NYSOH reviewed that documentation and calculated your annual expected income to be $23,920.00, and utilized that amount in its eligibility determination.

You are in a one-person household. You expect to file your 2017 income taxes as single and will claim no dependents on that tax return.

You reside in Kings County, where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month in 2017.

An annual income of $23,920.00 is 201.35% of the 2016 FPL for a one-person household. At 201.35% of the FPL, the expected contribution to the cost of the health insurance premium is 6.48% of income, or $129.17 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 ($456.46 per month) minus your expected contribution ($129.17 per month), which equals $327.29 per month. Therefore, rounding to the nearest

dollar, NYSOH correctly determined you to be eligible for up to $327.00 per month in APTC, based on NYSOH's calculations of your income.

NYSOH also found you eligible for cost-sharing reductions, based on its calculation of your income. Cost-sharing reductions are available to a person who has a household income no greater than 250% of the applicable FPL. Since a household income of $23,920.00 is 201.35% of the applicable FPL, NYSOH correctly found you to be eligible for cost-sharing reductions, based on its calculation of your income.

However, it is unclear how NYSOH arrived at an expected annual income of $23,920.00. Though you did not provide your final paystub after the hearing, you previously provided four consecutive weekly paystubs from September and October 2017 – the paystubs NYSOH used to determine your eligibility – so those paystubs are utilized in this decision to calculate your expected annual 2017 income.

The year-to-date income on your October 12, 2017 paystub was $15,107.00. This income represents 41 weeks of earnings, and, therefore, eleven weeks of earnings remained between this paystub and your final 2017 pay check. The four paychecks you provided averaged to a weekly wage of $164.02. Eleven weeks at $164.02 per week is $1,804.22. Therefore, based on the information in the paystubs you provided to NYSOH, your expected annual income for 2017 was $16,911.22 ($15,107,00 + $1,804.22), and <u>not</u> $23,920.00.

As the October 17, 2017 eligibility determination is based on a miscalculation of your expected annual income, it is RESCINDED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance, effective November 1, 2017, based on a household of one with an expected annual income of $16,911.22, residing in Kings County.

NYSOH is directed to notify you promptly in writing of your eligibility, and to permit you to enroll in coverage retroactively to November 1, 2017, should you choose to do so.

Depending on your eligibility, you will be responsible for any outstanding premiums should you choose to backdate your coverage to November 1, 2017.

Decision

The October 17, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, effective November 1, 2017, based on a one-person household with an expected annual income of $16,911.22, residing in Kings County.

NYSOH is directed to notify you of your eligibility in writing, and to assist you in enrolling in coverage retroactive to November 1, 2016, should you choose to do so.

Depending on your eligibility, you will be responsible for any outstanding premiums should you choose to backdate your coverage to November 1, 2017.

Effective Date of this Decision: February 06, 2018

How this Decision Affects Your Eligibility

NYSOH incorrectly determined your annual expected income for 2017 to be $23,920.00.

Your case is being sent back to NYSOH to redetermine your eligibility, effective November 1, 2017, based on an annual expected income of $16,911.50.

NYSOH will notify you in writing of your eligibility.

NYSOH will assist you in enrolling in coverage retroactive to November 1, 2017, if you wish to do so.

Depending on your eligibility, you will be responsible for premiums you incur if you choose to backdate your coverage.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your appeal was decided, the 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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 17, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, effective November 1, 2017, based on a one-person household with an expected annual income of $16,911.22, residing in Kings County.

NYSOH is directed to notify you of your eligibility in writing, and to assist you in enrolling in coverage retroactive to November 1, 2016, should you choose to do so.

Depending on your eligibility, you will be responsible for any outstanding premiums should you choose to backdate your coverage to November 1, 2017.

NYSOH incorrectly determined your annual expected income for 2017 to be $23,920.00.

Your case is being sent back to NYSOH to redetermine your eligibility, effective November 1, 2017, based on an annual expected income of $16,911.50.

NYSOH will notify you in writing of your eligibility.

NYSOH will assist you in enrolling in coverage retroactive to November 1, 2017, if you wish to do so.

Depending on your eligibility, you will be responsible for premiums you incur if you choose to backdate your coverage.

Legal Authority

We are sending you this notice in accordance with 45 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).

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 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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