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

Notice of Decision

Decision Date: February 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024416

[redacted]

[redacted]

On January 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 18, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: February 8, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000024416

[redacted]

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 $104.00 per month in advance payments of the premium tax credit (APTC), and not eligible for cost-sharing reductions, the Essential Plan or Medicaid, effective December 1, 2017?

Procedural History

On October 17, 2017, you uploaded income documentation and your eligibility for financial assistance was redetermined.

On October 18, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $104.00 per month in APTC and not eligible for cost-sharing reductions, the Essential Plan or Medicaid because your income was over the allowable income limits for those programs.

On November 16, 2017, you spoke to NYSOH's Account Review Unit and appealed the amount of financial assistance for which you were determined eligible insofar as you believe your annual income for 2017 was incorrectly determined.

On January 8, 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 15, 2018, to allow you to submit supporting documents.

On January 11, 2018, you uploaded income documentation to your NYSOH account which was made part of the record as “Appellant’s Exhibit 1.” The record was closed that day.

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 insurance for yourself.

3) You uploaded income documentation to your NYSOH account on October 17, 2017 which consisted of the following:
    a. Pay stub from [redacted] with a pay date of September 1, 2017 and a gross pay amount of $418.60;
    b. Pay stub from [redacted] with a pay date of September 8, 2017 and a gross pay amount of $490.60;
    c. Pay stub from [redacted] with a pay date of September 15, 2017 and a gross pay amount of $554.26;
    d. Pay stub from [redacted] with a pay date of September 22, 2017 and a gross pay amount of $283.66;
    e. Pay stub from [redacted] on with a pay date of September 29, 2017 and a gross pay amount of $291.85;
    f. Pay stub from [redacted] with a pay date of October 6, 2017 and a gross pay amount of $297.70;
    g. Pay stub from [redacted] with a pay date of October 13, 2017 and a gross pay amount of $274.69.

4) The application that was submitted on October 17, 2017 listed annual household income of $43,680.40, consisting of $43,680.40 you earn from your employment. You testified that this amount was incorrect.

5) NYSOH records reflect that your 2017 household income was determined to be $43,680.40 based on income from three employers; [redacted] $22,712.56, [redacted] $19,051.44 and [redacted] $1916.40.

6) You testified that your employer [redacted] was purchased by [redacted] in September 2017 and that you only had two employers in 2017. You testified that the company name changed in September 2017 from [redacted] to [redacted]

7) You testified that NYSOH incorrectly determined that [redacted] were two separate employers for which you simultaneously worked and received income.

8) Based on the 4 weekly pay stubs you provided from [redacted], your average weekly gross pay was $436.78. The pay stub dated November 24, 2017 you provided from [redacted] indicates that your year to date earnings were $16,661.17 through November 17, 2017.

9) Six weekly pay periods are not included in the pay stub reflecting your gross earnings for 2017 from [redacted] (November 19, 2017 through December 30, 2017). Six of your average gross weekly pay amounts ($436.78) totals $2,620.68.

10) Your gross income for 2017 from [redacted] was $16,661.17 plus $2,620.68 for a total of $19,281.85.

11) You testified that you were also employed by [redacted] during 2017.

12) On January 11, 2018, you uploaded the following:
    a. Pay stub with a pay date of November 24, 2017 from [redacted] in the amount of $265.98 reflecting a year to date total of $16,661.17;
    b. Pay stub with a pay date of December 29, 2017 from [redacted] in the amount of $86.40 reflecting a year to date total of $3,417.66.

13) Your gross income for 2017 from [redacted] was $3,417.86.

14) Your 2017 household income is $22,699.51 ([redacted] $19,281.85) plus ([redacted] $3,417.66).

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

16) Your application states that you live in Queens County.

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)).

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.).

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.).

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).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible to receive up to $104.00 per month in APTC, and not eligible for cost-sharing reductions, the Essential Plan, or Medicaid.

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.

The application that was submitted on October 17, 2017 listed annual household income of $43,680.40, consisting of $43,680.40 you earn from your employment. You testified that this amount was incorrect.

NYSOH records reflect that on October 17, 2017, your 2017 household income was determined to be $43,680.40 based on income from three employers; [redacted] $22,712.56, [redacted] $19,051.44 and [redacted] $1,916.40.

You testified that NYSOH incorrectly determined that [redacted] were two separate employers for which you simultaneously worked and received income. You testified that [redacted] are the same employer because [redacted] purchased [redacted] in September 2017.

Based on the 4 weekly pay stubs you provided from [redacted], your average weekly gross pay was $436.78. The pay stub dated November 24, 2017 you provided from [redacted] indicates that your year to date earnings were $16,661.17 through November 17, 2017.

Six weekly pay periods are not included in the pay stub reflecting your gross earnings for 2017 from [redacted] (November 19, 2017 through December 30, 2017). Six of your average gross weekly pay amounts ($436.78) totals $2,620.68.

Your gross income for 2017 from [redacted] was $16,661.17 plus $2,620.68 for a total of $19,281.85.

You testified that you were also employed by [redacted] during 2017. You provided a pay stub with a pay date of December 29, 2017 from [redacted] reflecting a year to date total of $3,417.66.

Your 2017 household income is $22,699.51 ([redacted] $19,281.85) plus ([redacted] $3,417.66).

Therefore, the October 18, 2017 eligibility determination notice is RESCINDED and your case is being RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a one-person household residing in Queens County with a household income of $22,699.51, effective December 1, 2017.

Decision

The October 18, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a one-person household residing in Queens County with a household income of $22,699.51, effective December 1, 2017.

Effective Date of this Decision: February 8, 2018

How this Decision Affects Your Eligibility

NYSOH incorrectly determined your 2017 household income to be $43,680.40.

Your case is being RETURNED to NYSOH to redetermine your eligibility based on a one-person household residing in Queens County with a household income of $22,699.51, 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 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).

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 October 18, 2017 eligibility determination notice is RESCINDED.

Your case is being RETURNED to NYSOH to redetermine your eligibility based on a one-person household residing in Queens County with a household income of $22,699.51, effective December 1, 2017.

NYSOH incorrectly determined your 2017 household income to be $43,680.40.

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 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.

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.

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).