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

Notice of Decision

Decision Date: February 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024465

[redacted]

Dear [redacted],

On January 12, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 17, 2017 notice of 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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DEPARTMENT OF HEALTH
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Decision Date: February 20, 2018

NY State of Health Account ID: [redacted]
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Issues

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

> Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to $264.00 per month in advance payments of the premium tax credit (APTC), effective January 1, 2018?
>
> Did NYSOH properly determine that you were not eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan?

Procedural History

You updated your NYSOH application for financial assistance with your health insurance on November 28, 2016, at which time you stated your annual household income was $20,948.45.

On November 29, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan, effective January 1, 2017. You were subsequently enrolled in an Essential Plan through Healthfirst.

You renewed your NYSOH application for financial assistance with your health insurance on November 16, 2017, at which time you stated your annual household income was $33,280.00. That day, a preliminary eligibility

determination was prepared stating that you were eligible to receive up to $264.00 per month in APTC, effective January 1, 2018.

Also on November 16, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination insofar as you were not eligible to enroll in the Essential Plan. You also requested Aid to Continue, pending the outcome of your appeal.

On November 17, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $264.00 in APTC, effective January 1, 2018. That notice also stated that you were not eligible for cost-sharing reductions, the Essential Plan, or Medicaid, because your household income was over the allowable income limits for those programs.

On November 22, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan for a limited time, effective January 1, 2018. This was because your request for "Aid to Continue" was granted, pending the outcome of your appeal.

Also on November 22, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan, beginning January 1, 2018, pending the outcome of your appeal.

On January 12, 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 26, 2018, to allow you time to submit supporting documents.

On January 12, 2018, NYSOH received your supporting documents by fax. The documents were incorporated into the record as Appellant's Exhibit #1 and the record was 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) You are seeking insurance for yourself.

3) The application that was submitted on November 16, 2017 listed expected annual household income of $33,280.00 for 2018, consisting of income you earn from your employment. You testified that this amount was correct. You began working at that job in December 2016, worked there for all 2017, and expect to work there all of 2018.

4) You testified that you are paid biweekly, earning $16.00 per hour for a 40-hour work week. You have five paid days off per year, but you are not paid for holidays. You have no pre-tax amounts taken out of your pay check.

5) You testified that you will not be taking any deductions on your 2017 tax return.

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

7) You testified that you cannot afford to enroll in health coverage with only a tax credit.

8) You submitted your last pay stub for 2017, dated December 29, 2017. It indicated that your gross year-to-date income, including overtime pay, vacation pay, and a bonus, was $34,673.28. It also indicated that although you did not make such a payment for the pay period in question, you had made total year-to-date payments of $284.86 for "Health Ins – Pretax."

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 qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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 2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is $12,060.00 for a one-person household (82 Federal Register 8831).

For annual household income in the range of at least 250% but less than 300% of the applicable 2017 FPL, the expected contribution for 2018 is between 8.1% and 9.56% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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 qualified health plan 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 qualified health plan (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 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to receive up to $264.00 per month in APTC.

The application that was submitted on November 16, 2017 listed an annual household income of $33,280.00, and the eligibility determination relied upon that information. Additionally, during the hearing, you testified that the amount you provided in your application was correct.

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 $509.30 per month.

An annual income of $33,280.00 is 275.95% of the 2017 FPL for a one-person household. At 275.95% of the FPL, the expected contribution to the cost of the health insurance premium is 8.86% of income, or $245.72 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 $509.30 per month) minus your expected contribution $245.72 per month), which equals $263.58 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $264.00 per month in APTC.

The second issue under review is whether you were properly found ineligible for cost-sharing reductions. 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 $33,280.00 is 275.95% 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 not 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 $12,060.00 for a one-person household. Since an annual household income of $33,280.00 is 275.95% of the 2017 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

It is noted that you submitted a copy of your final paystub for 2017, and it indicated that your gross annual income was $34,673.28. Even if the apparent pretax deduction for health insurance of $284.86 is considered, the income documented by this paystub is greater than that included on your application, so this would result in a lower level of financial assistance.

Because the November 17, 2017 notice of eligibility determination properly stated that, based on the information you provided in your application, you were eligible for up to $264.00 per month in APTC, and ineligible for cost-sharing reductions, the Essential Plan, and Medicaid, it is correct and is AFFIRMED.

Decision

The November 17, 2017 notice of eligibility determination is AFFIRMED.

Effective Date of this Decision: February 20, 2018

How this Decision Affects Your Eligibility

You remain eligible to receive up to $264.00 in APTC.

You are ineligible for cost-sharing reductions, the Essential Plan, and Medicaid.

PLEASE NOTE: If you take more tax credit in advance than you are found eligible for when you file your tax return in 2018, you will owe the difference in additional income taxes. Additionally, if you are eligible to enroll in minimum essential coverage through your employer, you are not eligible to receive the tax credit for purchasing insurance through NYSOH.

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 November 17, 2017 notice of eligibility determination is AFFIRMED.

You remain eligible to receive up to $264.00 in APTC.

You are ineligible for cost-sharing reductions, the Essential Plan, and Medicaid.

PLEASE NOTE: If you take more tax credit in advance than you are found eligible for when you file your tax return in 2018, you will owe the difference in additional income taxes. Additionally, if you are eligible to enroll in minimum essential coverage through your employer, you are not eligible to receive the tax credit for purchasing insurance through NYSOH.

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).