



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

## Notice of Decision

Decision Date: March 05, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024962

[REDACTED]

Dear [REDACTED],

On January 23, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 25, 2017 eligibility determination notice and November 14, 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: March 05, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024962



## 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 \$265.00 per month in advance payments of the premium tax credit (APTC), effective November 1, 2017?

Did NYSOH properly determine that you were eligible for cost-sharing reductions?

Did NYSOH properly determine that your enrollment in a qualified health plan and the application of APTC were effective no earlier than December 1, 2017?

## Procedural History

On July 10, 2017, you submitted an application for financial assistance.

On July 11, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan for a limited time, effective August 1, 2017. You were directed to produce income documentation by October 8, 2017.

Also on July 11, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in an Essential Plan, effective August 1, 2017.

On October 14, 2017, an application for financial assistance was run systematically on your behalf.

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On October 15, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$265.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective November 1, 2017. The notice stated that your eligibility was based on federal and state data sources showing that your household income was between \$16,395.00 and \$47,520.00.

On November 14, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in a qualified health plan, effective December 1, 2017.

On November 15, 2017, NYSOH issued a renewal notice stating that you were qualified to receive up to \$299.30 per month in APTC, effective January 1, 2018. The notice further stated that you were re-enrolled in your health plan and that no action was required.

On November 28, 2017 you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not determined eligible for the Essential Plan, effective November 1, 2017.

On January 17, 2018, NYSOH issued an eligibility determination notice stating that you were eligible for the Essential Plan for a limited time because you were granted Aid to Continue until a decision is made on your appeal.

Also on January 17, 2018, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan, effective November 1, 2017.

Also on January 17, 2018, NYSOH issued notices of modification to termination of your qualified health and dental plans because you had been granted Aid to Continue in your Essential Plan instead.

On January 23, 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 to February 6, 2018, to allow you to submit supporting documents.

On January 24, 2017, you submitted the requested documentation and it 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 health insurance for yourself; specifically, the Essential Plan as of November 1, 2017.
- 3) The application that was submitted on July 10, 2017, listed annual household income of \$20,800.00, consisting of income you earn from your employment. You testified that you expect to earn around \$31,000.00 annually.
- 4) The application that was submitted on October 14, 2017 does not indicate the income amount used to determine your eligibility, but the record reflects that your income was at 243.25% of the 2016 FPL.
- 5) You submitted four paystubs:
  - a. dated November 3, 2017 for a gross amount of \$1,286.10;
  - b. dated November 17, 2017 for a gross amount of \$1,264.56;
  - c. dated December 1, 2017 for a gross amount of \$1,286.43;
  - d. dated December 15, 2017 for a gross amount of \$1,268.35.
- 6) Your application states that you will not be taking any deductions on your 2017 tax return.
- 7) According to your NYSOH account and testimony, you receive notices from NYSOH by electronic mail.
- 8) You testified that you did not receive any electronic alerts regarding any notice in your NYSOH account telling you that you needed to pick a plan in order to have coverage.
- 9) You testified that you did not receive the October 15, 2017 notice in the mail directing you to pick a health plan.
- 10) NYSOH uploaded an evidence packet to your NYSOH account. Contained within that evidence packet under the heading of “electronic notice requirement” is a three-page memorandum dated August 21, 2017. The memorandum sets forth the federal requirements regarding use of electronic communications and asserts that NYSOH is in compliance with federal regulation and guidance on the use of electronic notices. The memorandum asserts that “the electronic notification rules do not require that exchanges track and monitor consumers actual receipt of electronic notices.”
- 11) Your application states that you live in [REDACTED], NY.

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 300% of the 2016 FPL, the expected contribution is between 6.43% 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

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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)).

### Enrollment in a Qualified Health Plan

The effective date of coverage by a qualified health 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)). 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)).

### 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>).

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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)).

### Electronic Notices

If the individual elects electronic communications, NYSOH must send an email or other electronic communication alerting the individual that a notice has been posted to his or her account and send a notice by regular mail within three business days if the electronic communication cannot be delivered (45 CFR § 155.230(d); 42 CFR § 435.918(b)(4), (5)).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to \$265.00 per month and cost-sharing reductions, effective November 1, 2017.

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.

On October 14, 2017, NYSOH ran an application for financial assistance on your behalf, which resulted in an eligibility determination notice stating that you were eligible to receive up to \$265.00 in APTC and cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective November 1, 2017. Although the application does not indicate the income used to determine your eligibility, the October 15, 2017 notice states that your household income was between \$16,395.00 and \$47,520.00. Furthermore, the record reflects that your income was at 243.25% of the 2016 FPL.

At 243.25% of the FPL, the expected contribution to the cost of the health insurance premium is 7.97% of income, or in your case, \$191.93 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 (\$191.93 per month), which equals \$264.53 per month. Therefore, rounding to the nearest

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dollar, NYSOH correctly determined you to be eligible for up to \$265.00 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 your household income was 243.25% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

Since the October 15, 2017 eligibility determination notice properly stated that, based on the information in your account, you were eligible to receive up to \$265.00 per month in APTC and eligible for cost-sharing reductions effective November 1, 2017, it is correct and is AFFIRMED.

The third issue under review is whether NYSOH properly determine that your enrollment in a qualified health plan, as well as the application of APTC, was effective no earlier than December 1, 2017.

The record shows that November 13, 2017, you requested to enroll in a qualified health plan. On November 14, 2017, NYSOH issued a plan enrollment notice stating that your enrollment in your qualified health plan was effective December 1, 2017.

When an individual changes information in their application on or before the 15th of any month, NYSOH must make the redetermination that results from the change effective the first day of the following month. Additionally, the date on which a qualified health 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 fifteenth day of a month goes into effect on the first day of the following month.

Because you did not respond to the October 15, 2017 notice in effect at the time or select a plan until November 13, 2017, your enrollment in a qualified health plan did not begin until December 1, 2017.

However, you testified and the record reflects that you elected to receive alerts regarding notices from NYSOH electronically. Although NYSOH contends that it complied with federal mandates regarding electronic notices, there is no evidence in the file that NYSOH sent you an electronic alert notifying you of a new notice available in your account on October 15, 2017. You credibly testified that you did not receive an electronic alert regarding the eligibility determination notice, which directed you to pick a plan. There is also no evidence in your account documenting that any email alert was sent to you regarding the notice, that any such electronic alert failed, or that the notice was later sent to you by regular mail.

NYSOH is required to send applicants proper notice in order for applicants to take appropriate action. Since there is no evidence that NYSOH sent you an email alert, and you testified that you did not receive one, there is insufficient evidence in the record that NYSOH provided you with proper notice by electronic means that you needed to select a plan in order to be enrolled into coverage effective November 1, 2017.

You first selected a plan on November 13, 2017, and therefore we must assume that this is the information that would have been used had you been timely informed of the need to select a plan, as stated in the October 15, 2017 eligibility determination notice. Had you been timely notified, you could have selected a plan on October 15, 2017. Had you selected a plan on October 15, 2017, you would have been enrolled in a qualified health plan effective November 1, 2017. Therefore, the November 14, 2017 plan enrollment notice is MODIFIED to state that your enrollment in a qualified health plan is effective November 1, 2017.

Notwithstanding, it is noted that you had health insurance coverage in an Essential Plan as Aid to Continue, effective November 1, 2017 and throughout this appeal process.

Following the hearing, you submitted four paystubs: dated November 3, 2017 for a gross amount of \$1,286.10; dated November 17, 2017 for a gross amount of \$1,264.56; dated December 1, 2017 for a gross amount of \$1,286.43; and dated December 15, 2017 for a gross amount of \$1,268.35. A reasonable calculation using the average of these paystubs yields an annual expected gross income of \$33,185.36 ( $\$5,105.44 / 8 \text{ weeks} = \$638.18 \text{ average per week} \times 52 \text{ weeks per year} = \$33,185.36$ ).

Now that the record contains a more current and accurate representation of your annual expected gross income, your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, using an annual expected income of \$33,185.36 and a one-person household, for an individual residing in Queens County.

## **Decision**

The October 15, 2017 eligibility determination notice is AFFIRMED.

The November 14, 2017 enrollment notice is MODIFIED to state that your enrollment in a qualified health plan is effective November 1, 2017. However, you had health insurance coverage in an Essential Plan as Aid to Continue, effective November 1, 2017 and throughout this hearing process.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, using an annual expected income of \$33,185.36 and a one-person household, for an individual residing in Queens County.

**Effective Date of this Decision:** March 05, 2018

### **How this Decision Affects Your Eligibility**

NYSOH properly determined you eligible to receive up to \$265.00 in APTC.

NYSOH properly determined you eligible for cost-sharing reductions.

Your enrollment in your qualified health plan should have begun on November 1, 2017, but you had health insurance coverage as of then in an Essential Plan as Aid to Continue.

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility based on your testimony and the developed record.

### **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

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).

- 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:  
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Albany, NY 12211
- By fax: 1-855-900-5557

### **Summary**

The October 15, 2017 eligibility determination notice is AFFIRMED.

NYSOH properly determined you eligible to receive up to \$265.00 in APTC.

NYSOH properly determined you eligible for cost-sharing reductions.

The November 14, 2017 enrollment notice is MODIFIED to state that your enrollment in a qualified health plan is effective November 1, 2017. However, you had health insurance coverage in an Essential Plan as Aid to Continue, effective November 1, 2017 and throughout this hearing process.

Your enrollment in your qualified health plan should have begun on November 1, 2017, but you had health insurance coverage as of then in an Essential Plan as Aid to Continue.

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).

This is not a final determination of your eligibility.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, using an annual expected income of \$33,185.36 and a one-person household, for an individual residing in Queens County.

### **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&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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