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

Notice of Decision

Decision Date: February 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025555

[redacted]

[redacted]

On February 14, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 30, 2017 eligibility determination 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).

This page intentionally left blank.

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

Decision

Decision Date: February 27, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025555

[redacted]

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 $0.00 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?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On November 28, 2017, you updated your application for financial assistance through NYSOH. In that application, you indicated that your spouse was not applying for coverage, and that you expected to file your federal income tax return as married, filing single.

On November 29, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to purchase a qualified health plan (QHP) at full cost, effective January 1, 2018. The notice further stated that you were not eligible for Medicaid or the Essential Plan because your household income was over the allowable income limit for those programs. Finally, the notice also stated

that you were not eligible for APTC or cost-sharing reductions because you said you would not be filing a tax return; or were married and filing separately; or you did not file a tax return for an earlier year during which you received APTC.

On December 8, 2017, you updated your application again, and changed your application to state that you expected to file your federal income tax return as married, filing jointly. That same day, you spoke to NYSOH's Account Review Unit and filed an appeal, insofar as NYSOH did not find you eligible for financial assistance that day.

On December 9, 2017, NYSOH issued a notice stating that the income information in your December 8, 2017 application did not match the income information NYSOH received from stated and federal data sources. The notice directed you to submit documentation of your income by December 23, 2017.

On December 12, 2017, you uploaded documentation to your NYSOH account.

On December 14, 2017, NYSOH issued a notice stating that the documentation you provided did not confirm the information in your application. The notice directed you to submit documentation of your income by January 7, 2018.

On December 29, 2017, you uploaded additional documentation.

Also on December 29, 2017, NYSOH redetermined your household's eligibility for financial assistance.

On December 30, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive $0.00 in APTC, effective February 1, 2018, and that your two children were eligible to enroll in Child Health Plus with a $30.00 monthly premium each, effective January 1, 2018.

On February 14, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. During the hearing, the issue under review was amended to reflect that you were now appealing the December 30, 2017 eligibility determination that found you eligible for $0.00 in APTC. The record was developed during the hearing and closed at the end 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 tax return for 2018 with a tax filing status of married filing jointly. You will claim two dependents on that tax return.

2) You are appealing on behalf of yourself only.

3) On December 12, 2017, you submitted four consecutive weekly paystubs for yourself for the following dates and gross pay amounts:

   a. 11/16/2017: $790.00 [redacted]
   b. 11/22/2017: $765.00 [redacted];
   c. 11/30/2017: $460.00 [redacted]);
   d. 12/7/2917: $615.00, year-to-date of $28,944.50 [redacted].

4) NYSOH calculated your expected annual income to be $41,600.00, and utilized this figure in the December 30, 2017 eligibility determination.

5) On December 12, 2017, you submitted one paystub for your spouse, dated December 1, 2017, for gross biweekly pay of $1,050.00, and year-to-date pay of $1,568.00 [redacted]

6) On December 29, 2017, you submitted an additional biweekly paystub for your spouse dated December 29, 2017 for gross pay of $1,050.00, and year-to-date pay of $3,720.89 [redacted]

7) NYSOH calculated your spouses expected annual income to be $26,936.00, and utilized this figure in the December 30, 2017 eligibility determination.

8) You testified that you generally work between 37.5 and 40 hours per week, and that you earn $20.00 per hour. You testified that the paystubs you submitted are representative of your income.

9) You testified that your spouse started working in November 2017.

10) You testified that your spouse works 37.5 hours per week, and that she earns $14.00 an hour, but that her hourly rate went up to $15.00 an hour on February 1, 2018. You testified that the paystubs you submitted are representative of her income.

11) You testified that you have no reason to believe that either of your incomes will further increase or decrease in 2018.

12) Your application states that you will not be taking any deductions on your 2018 tax return, and you confirmed this in your testimony.

13) Your application states that you live in Ontario County.

14) You testified that you cannot afford the cost of a QHP, as you are currently paying community college tuition and day care costs.

15) You testified that you have a chronic health condition, and that your health is beginning to deteriorate because you cannot afford the supplies you need to maintain our health, and cannot afford to pay for a QHP.

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 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 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 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 $24,600.00 for a four-person household (82 Federal Register 8831).

For annual household income in the range of at least 250% but less than 300% of the 2017 FPL, the expected contribution is between 8.10% 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 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 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 $24,600.00 for a four-person household (82 Fed. Reg. 8831).

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 $24,600.00 for a four-person household (82 Fed. Reg. 8831).

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 first issue under review is whether NYSOH properly determined that you were eligible to receive $0.00 per month in APTC, effective February 1, 2018.

You submitted income documentation on December 12, 2017 and December 29, 2017. NYSOH reviewed this documentation and determined that your total expected annual household income for 2018 was $68,536.00, and the eligibility determination was based on this amount.

You are in a four-person household. You expect to file your 2018 income tax return as married filing jointly and will claim two dependents on that tax return.

You reside in Ontario County, where the second lowest cost silver plan available for an individual through NYSOH costs $449.12 per month.

An annual income of $68,536.00 is 278.60% of the 2017 FPL for a four-person household. At 278.60% of the FPL, the expected contribution to the cost of the health insurance premium is 8.94% of income, or $510.50 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 ($449.12 per month) minus your expected contribution ($510.50 per month). Since the result of this calculation is a negative number, NYSOH

determined you to be eligible for $0.00 per month in APTC, based on NYSOH's calculation of your income.

However, NYSOH's calculation of your expected annual income is not supported by the income documentation you submitted. The four weekly paystubs you submitted total $2,630.00, for an average weekly income of $657.50 ($2,630.00 divided by four). Therefore, your expected annual income should be $34,190.00 ($657.50 times 52 weeks in a year), and not $41,600.00

Likewise, NYSOH's calculation of your spouse's income is incorrect. The two biweekly paystubs you submitted for December 2017 were each for $1,050.00. At this rate of pay, your spouses expected annual income should have been $27,300.00.

As such, NYSOH's determination that you are eligible for $0.00 per month in APTC cannot be affirmed, as it is based on inaccurate income information.

The second issue under review is whether you were properly determined 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 $68,535.00 is 278.60% of the applicable FPL, NYSOH found you to be ineligible for cost sharing reductions. However, as NYSOH's income figure is incorrect, this determination cannot be affirmed.

The third issue under review is whether NYSOH properly determined you were ineligible for the Essential Plan.

The Essential Plan is generally 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 $24,600.00 for a four-person household. Since an annual household income of $68,536.00 is 278.60% of the 2017 FPL, NYSOH found you to be ineligible for the Essential Plan. However, again, as NYSOH's income figure is incorrect, this determination cannot be affirmed.

The fourth issue under review is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $24,600.00 for a four-person household. Since $68,536.00 is 278.60% of the 2017 FPL, NYSOH found you to be ineligible for Medicaid on an expected annual income basis,

using the information provided in your application. Once again, this conclusion cannot be affirmed at this time.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted documentation that shows your spouse earned $3,202.89 in December 2017, and you earned at least $615.00, for a total of $3,817.89.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $2,829.00 per month. While you have not submitted complete documentation of your own December 2017 income, the documentation you have provided shows that your December 2017 household income was at least $3,817.89, and therefore you do not qualify for Medicaid based on monthly income as of the date of your application.

During the hearing, you testified that your spouse's hourly wage went from $14.00 to $15.00 an hour as of February 1, 2018. As her hourly wage was $14.00 an hour in January 2018, her income from that month, at 37.5 hours per week, would have been $2,100.00, based on two biweekly paychecks. As of February 2018, her biweekly income would have increased to $1,125.00 (37.5 hours per week at $15.00 an hour). Therefore, your spouse's new expected annual income, based on the information provided during the hearing, is $29,100.00. Your total expected household income for 2018 is $63,290.00.

Since the December 30, 2017 eligibility determination notice was based on an incorrect calculation of your expected annual income and is unsupported by the record, it is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household's eligibility for financial assistance for 2018 based on a four-person household with an expected annual income of $63,290.00, residing in Ontario County.

NYSOH is directed to notify you in writing of your new eligibility.

Decision

The December 30, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household's eligibility for financial assistance in 2018 based on a four-person household with an expected annual income of $63,290.00, residing in Ontario County.

Effective Date of this Decision: February 27, 2018

How this Decision Affects Your Eligibility

NYSOH's determination of your eligibility for financial assistance was based on an incorrect calculation of your annual household income.

Your case is being sent back to NYSOH to redetermine your household's eligibility for financial assistance based on the income documentation in the record, and the information you provided at the hearing.

NYSOH will notify you promptly in writing of your new eligibility.

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 case 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
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The December 30, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your household's eligibility for financial assistance in 2018 based on a four-person household with an expected annual income of $63,290.00, residing in Ontario County.

NYSOH's determination of your eligibility for financial assistance was based on an incorrect calculation of your annual household income.

Your case is being sent back to NYSOH to redetermine your household's eligibility for financial assistance based on the income documentation in the record, and the information you provided at the hearing.

NYSOH will notify you promptly in writing of your new eligibility.

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).