



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

Notice of Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025901

[REDACTED]

Dear [REDACTED],

On February 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 16, 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).

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DEPARTMENT OF HEALTH
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Decision

Decision Date: March 14, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025901

[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 up to \$277.00 per month in advance payments of the premium tax credit (APTC), effective January 1, 2018?

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

Did NYSOH properly determine that you were not eligible for the Essential Plan?

Procedural History

On December 15, 2017, you applied for health insurance and financial assistance through NYSOH.

That day, a preliminary eligibility determination was prepared stating that you were eligible to receive up to \$277.00 in APTC and eligible for cost-sharing reductions, effective January 1, 2018.

Also on December 15, 2017, you spoke to NYSOH's Account Review Unit and appealed that preliminary eligibility determination notice insofar as you were not eligible for the Essential Plan.

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On December 16, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$277.00 in APTC, as well as cost-sharing both effective January 1, 2018. That notice also stated that you were not eligible for the Essential Plan because your annual household income was over the allowable income limit for that program.

On January 4, 2018, NYSOH issued a notice stating that you were eligible for the Essential Plan with a \$20.00 monthly premium, for a limited time, effective January 1, 2018. This was because you had been granted Aid to Continue pending the outcome of your appeal.

Also on January 4, 2018, NYSOH issued a plan enrollment notice stating that you were enrolled in an Essential Plan, effective January 1, 2018.

On February 21, 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 March 7, 2018, to allow you time to submit supporting documents.

On March 6, 2018, NYSOH received your supporting documents. The documents made part of 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 tax return for 2018 with a tax filing status of single. You will claim one dependent on that tax return.
- 2) You are seeking health insurance for yourself.
- 3) The application that was submitted on December 15, 2017, listed annual household income of \$32,500.00, consisting of income earned from your employment.
- 4) You testified that you entered your annual income as \$32,500.00 on the December 15, 2017 application, but that this amount is incorrect in that you earn less than the amount you entered.
- 5) You testified, and provided documentation in the form of paystubs, that you are an hourly employee and earn \$16.00 per hour. You testified that your hours vary and you do not work a consistent number of hours a week.

- 6) You provided a copy of your paystubs for January 5, 2018 through February 9, 2018, which show that your year to date gross income is \$3,456.00.
- 7) You testified your only source of income is from your employment and that you do not have any other income.
- 8) Your application states that you will not be taking any deductions on your 2018 tax return.
- 9) Your application states that you live in Monroe County, 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

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 \$16,240.00 for a two-person household (82 Federal Register 8831).

For annual household income in the range of at least 200% but less than 250% of the 2017 FPL, the expected contribution in 2018 is between 6.34% and 8.10% 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 \$16,240.00 for a two-person household (82 Fed. Reg. 8831).

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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/downloads/ny-blueprint.pdf>).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a \$20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for up to \$277.00 per month in APTC.

The application that was submitted on December 15, 2017, listed an annual household income of \$32,500.00, and NYSOH relied on this information when determining your eligibility for financial assistance for health insurance.

You are in a two-person household for purposes of this analysis. This is because you expect to file your 2018 income tax return as single and will claim one dependent on that tax return.

You reside in Monroe County, where the second lowest cost silver plan available for an individual through NYSOH costs \$449.11 per month.

An annual income of \$32,500.00 is 200.12% of the 2017 FPL for a two-person household. At 200.12% of the FPL, the expected contribution to the cost of the health insurance premium is 6.34% of income, or \$171.82 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 (\$449.11 per month) minus your expected contribution (\$171.83 per month), which equals \$277.30 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$277.00 per month in APTC.

The second issue under review is whether you were properly determined 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 a

household income of \$32,500.00 is 200.12% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined you were not eligible 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 \$16,240.00 for a two-person household. Since an annual household income of \$32,500.00 is 200.12% of the 2017 FPL, NYSOH correctly found you were not eligible for the Essential Plan.

Since the December 16, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$277.00 per month in APTC, eligible for cost-sharing reductions, and not eligible for the Essential Plan, it is correct and is AFFIRMED.

However, you testified that the annual household income of \$32,500.00 was incorrect and that you earn less than this amount. You submitted evidence that corroborated your testimony.

You provided paystubs from your employment, dated January 5, 2018 through February 9, 2018, which is the first six weeks of 2018. These paystubs show that as of February 9, 2018, your gross annual income was \$3,458.00. Therefore, your gross average salary is \$576.00 per week (the result of \$3,458.00 divided by six). Since there are 52 weeks in a year, and your average weekly salary is \$576.00, your 2018 gross income is \$29,952.00 (the result of \$576.00 multiplied by 52).

Since the record now contains a more accurate representation of your household income, your case is RETURNED to NYSOH to redetermine your eligibility based on a household size of two people, for an individual residing in Monroe county with a household income of \$29,952.00.

Decision

The December 16, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a household size of two people, for an individual residing in Monroe county with a household income of \$29,952.00.

Effective Date of this Decision: March 14, 2018

How this Decision Affects Your Eligibility

NYSOH was proper to determine you were eligible for \$277.00 in APTC and cost-sharing reductions, and ineligible for the Essential Plan, based on the information available in your NYSOH account at that time the determination was made.

This is not a final determination of your eligibility for financial assistance going forward. Your case is being sent back to NYSOH to redetermine your eligibility based on the information you submitted during your hearing.

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

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:
NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The December 16, 2017 eligibility determination notice is **AFFIRMED**.

Your case is **RETURNED** to NYSOH to redetermine your eligibility for financial assistance based on a household size of two people, for an individual residing in Monroe county with a household income of \$29,952.00.

NYSOH was proper to determine you were eligible for \$277.00 in APTC and cost-sharing reductions, and ineligible for the Essential Plan, based on the information available in your NYSOH account at that time the determination was made.

This is not a final determination of your eligibility for financial assistance going forward. Your case is being sent back to NYSOH to redetermine your eligibility based on the information you submitted during your hearing.

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Legal Authority

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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 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।

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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&btumi ama wo obi a okyerE 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.