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

# Notice of Decision

Decision Date: April 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028248

On April 4, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 2, 2018 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.

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).

nystateofhealth
The Official Health Plan Marketplace

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

**Decision**

Decision Date: April 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000028248

[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 and your spouse were eligible to receive up to $686.00 per month in advance payments of the premium tax credit (APTC), effective March 1, 2018?
>
> Did NYSOH properly determine that you and your spouse were not eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you and your spouse were not eligible for the Essential Plan?

## Procedural History

On January 30, 2018, NYSOH received income documentation uploaded to your NYSOH account as Documents [redacted].

Also on January 30, 2018, NYSOH reviewed the income documentation you submitted and determined it was sufficient to verify your household's income. NYSOH recalculated your household income based on this information, updated the income in your household's application based on this recalculation, and then submitted an application on you and your spouse's behalf.

On January 31, 2018, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to receive up to $686.00 in APTC, effective March 1, 2018. That notice also stated that, as of February 28, 2018,

you and your spouse were no longer eligible for the Essential Plan because your annual household income was over the allowable income limits for that program.

On February 1, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you and your spouse were no longer eligible for the Essential Plan.

On February 2, 2018, NYSOH issued a second eligibility determination notice stating that you and your spouse were eligible to receive up to $686.00 in APTC, effective March 1, 2018. That notice also stated that, as of February 28, 2018, you and your spouse were no longer eligible for the Essential Plan because your annual household income was over the allowable income limits for that program.

On February 22, 2018, NYSOH issued a notice stating that you and your spouse were eligible for the Essential Plan for a limited time, effective February 22, 2018. This was because you and your spouse had been granted Aid to Continue pending the outcome of your appeal.

Also on February 22, 2018, NYSOH issued an enrollment confirmation notice stating that you and your spouse were enrolled in an Essential Plan, effective March 1, 2018.

On April 4, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was held open until April 19, 2018, to allow you time to submit supporting documents.

On April 4, 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 are seeking health insurance for yourself and your spouse.

2) You testified that you and your spouse expect to file your 2018 taxes with a tax filing status of married filing jointly. You and your spouse will not claim not claim any dependents on that tax return.

3) The January 30, 2018 application submitted by NYSOH on your and your spouse's behalf listed an annual household income of $46,800.00. This amount consisted of income your spouse earns from employment.

4) NYSOH determined the income in the January 30, 2018 application based on paystubs you submitted for your spouse.

5) You testified your spouse's income was incorrect because he owns his own business and that his income varies depending on the number of jobs he works in a given month. You testified that your spouse worked more jobs than usual during the months for which you submitted paystubs, so his income for those months was higher than usual.

6) You testified that your 2017 tax return is a better reflection of your household income because it accounts for the fluctuations in each month. You further testified that you believe your household income will be approximately the same in 2018.

7) You provided a copy of your and your spouse's filed 2017 tax return, which reflects that your annual household income for 2017 was $30,162.00.

8) You testified that you do not work and do not have any form of income.

9) Your application states that you and your spouse will not be taking any deductions on your 2018 tax return.

10) Your application states that you and your spouse live in [redacted] [redacted], NY.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

## Applicable Law and Regulations

<u>Advance Payments of Premium Tax Credit</u>

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 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 2018 FPL, which is $16,460.00 for a two-person household (83 Fed. Reg. 2642).

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 and your spouse eligible for up to $686.00 per month in APTC.

On January 30, 2018, you uploaded income documentation to your NYSOH account. That day, a NYSOH representative reviewed the income documentation you submitted and recalculated your household income based on that documentation. An application for financial assistance was submitted on your and your spouse's behalf by a NYSOH representative. The NYSOH representative entered your household income as $46,800.00 from income earned by your spouse, and the eligibility determination relied upon that information.

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).

You are in a two-person household for purposes of this analysis. This is because you and your spouse expect to file your 2018 income tax return as married filing jointly and will not claim any dependents on that tax return.

You and your spouse reside in Schenectady County, where the second lowest cost silver plan available for a couple through NYSOH costs $1,045.23 per month.

An annual income of $46,800 is 288.18% of the 2017 FPL for a two-person household. At 288.18% of the FPL, the expected contribution to the cost of the health insurance premium in 2018 is 9.21% of income, or $359.19 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 a couple in your county ($1,045.23 per month) minus your expected contribution ($359.19 per month), which equals $686.04 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to $686.00 per month in APTC.

The second issue under review is whether NYSOH properly determined that you and your spouse were not eligible for cost-sharing reductions. Cost-sharing reductions are available to persons with a household income no greater than 250% of the FPL. Since a household income of $46,800 is 288.18% of the applicable FPL for the applicable family size, NYSOH correctly found you and your spouse were not eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you and your spouse 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 for a two-person household. Since an annual household income of $46,800.00 is 288.18% of the 2017 FPL, NYSOH correctly found you and your spouse were not eligible for the Essential Plan.

Accordingly, the February 2, 2018 eligibility determination notice is AFFIRMED because, based on the information available at the time, NYSOH properly found you and your spouse to be eligible for $686.00 in APTC effective March 1, 2018, and ineligible for cost-sharing reductions and the Essential Plan.

However, you testified that the annual household income of $46,800.00 was incorrect because the income documentation upon which the calculation was based included income that your spouse does not typically receive every pay

period since it varies depending on the number of jobs he works in a given month. You submitted evidence that corroborated your testimony.

You provided a copy of your and your spouse's 2017 tax return that shows your annual household income was $30,162.00. You testified that you believe this is a more accurate representation of your household income because it accounts for the fluctuation in your household's monthly income, and that you believe your household income will be approximately the same in 2018.

Since the record now contains a more accurate representation of you and your spouse's income, your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance using an annual expected income of $30,162.00, for a two -person household, for a couple residing in Schenectady County, and to notify you of the new determination accordingly.

## Decision

The February 2, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance using an annual expected income of $30,162.00, for a two-person household, for a couple residing in Schenectady County, and to notify you of the new determination accordingly.

## Effective Date of this Decision: April 9, 2018

## How this Decision Affects Your Eligibility

NYSOH was proper to determine you and your spouse were eligible for $686.00 in APTC, and ineligible for cost-sharing reductions and the Essential Plan based on the information available in your NYSOH account at that time.

This is not a final determination of your eligibility for financial assistance. Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility based on the information you submitted during your hearing. NYSOH will notify you of the new determination once made.

## 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 February 2, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine you and your spouse's eligibility for financial assistance using an annual expected income of $30,162.00, for a two-person household, for a couple residing in Schenectady County, and to notify you of the new determination accordingly.

NYSOH was proper to determine you and your spouse were eligible for $686.00 in APTC, and ineligible for cost-sharing reductions and the Essential Plan based on the information available in your NYSOH account at that time.

This is not a final determination of your eligibility for financial assistance. Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility based on the information you submitted during your hearing. NYSOH will notify you of the new determination once made.

## Legal Authority

We are sending you this notice in accordance with 45 CFR § 155.545.

## A Copy of this Decision Has Been Provided To:

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 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 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.

**(Urdu)اردو**

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).