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

Notice of Decision

Decision Date: April 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029358

[redacted]

[redacted]

On April 19, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's February 23, 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
  PO Box 11729
  Albany, NY 12211

- Sending a Fax to 1-855-900-5557

When contacting NY State of Health about your appeal and/or the Decision, please refer to the Appeal Identification number and the Account ID at the top of this notice.

Legal Authority

We are sending you this notice in accordance with 45 Code of Federal Regulations (CFR) § 155.545(b).

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

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).

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

Decision

Decision Date: April 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000029358

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to $291.00 per month in advance payments of the premium tax credit, eligible for cost-sharing reductions, and not eligible for the Essential Plan, effective April 1, 2018?

Procedural History

On February 21, 2018, NYSOH received two earnings statements issued to you by your employer, [redacted]., on January 26, 2018 and February 9, 2018.

On February 22, 2018, NYSOH redetermined your eligibility for health insurance based on the information contained in your application as of February 20, 2018.

On February 23, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $291.00 in advance payments of the premium tax credit (APTC) as well as cost-sharing reductions (CSR) if you enrolled in a silver-level qualified health plan, effective April 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 limits for that program.

On February 26, 2018, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not eligible for the Essential Plan.

On March 9, 2018, NYSOH issued a notice stating that you were eligible for the Essential Plan for a limited time, effective March 1, 2018. This was because you had been granted Aid to Continue pending the outcome of your appeal.

On March 10, 2018, NYSOH issued an enrollment confirmation notice stating that you were enrolled in an Essential Plan, effective March 1, 2018.

On April 19, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. At your request, a Spanish-language interpreter ([redacted] also attended the hearing. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

A review of the record support the following findings of fact:

1) You testified that you expect to file your tax return for 2018 with a tax filing status of head of household. You will claim three dependents on that tax return, which includes your mother, father, and your son.

2) You are seeking insurance for yourself only since your son was already enrolled in Medicaid, and both your mother and father were not seeking health insurance through NYSOH.

3) The redetermination of your eligibility for financial assistance with health insurance listed annual household income of $36,400.01, consisting of you received of approximately $1,400.00 once every two weeks from your employment with [redacted]. You testified that this amount was reasonably accurate given your earning rate of $22.00 per hour over a typical 62 to 63 hours of work during a given two-week period.

4) Your NYSOH account reflects that you will not be taking any deductions on your 2018 tax return.

5) You live in New York County, New York.

6) You testified that you were seeking to be found eligible for the Essential Plan since you cannot afford plans through NYSOH, even after applying the full $291.00 of APTC. You testified that your living expenses were simply too high to make such plans, other than the Essential Plan, affordable.

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)).

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

Cost-Sharing Reductions

CSR 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).

Household Composition

For purposes of APTC and CSR, the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible to receive up to $291.00 per month in APTC, eligible for CSR, and not eligible for the Essential Plan, effective April 1, 2018.

The record reflects that your eligibility was redetermined on February 22, 2018, which was based on information contained in your account as of February 20, 2018, which listed an annual household income of $36,400.01, consisting of you received of approximately $1,400.00 once every two weeks from your employment with [redacted]. The eligibility determination relied upon that information.

You testified, and your NYSOH account reflects, that you expect to file your 2018 income tax return as head of household and will claim three dependents on that tax return, which includes your mother, father and son. Accordingly, you are in a four-person household.

The record reflects that based on the February 22, 2018 redetermination, you were found eligible for an APTC of up to $291.00 per month and, if you selected a silver-level plan, CSR. You were not found eligible for the Essential Plan since NYSOH determined that your income was over the income limit for that program.

On the date of your application, the relevant FPL was $24,600.00 for a four-person household. Accordingly, an annual income of $36,400.01 is 147.97% of the 2017 FPL for a four-person household.

This determination, however, was apparently based on a two-person household since your NYSOH account reflected that your annual household income of $36,400.01 equated to 224.14% of the applicable FPL.

Accordingly, we find that the February 23, 2018 eligibly determination notice was issued in error and must be RESCINDED.

Your case is RETURNED to NYSOH to redetermined your eligibility as of February 22, 2018, based on a four-person household in New York County, with an annual household income of $36,400.01.

Decision

The February 23, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to (1) redetermine your eligibility as of February 22, 2018, based on a four-person household in New York County, with an annual household income of $36,400.01 and (2) facilitate your enrollment in your new heath plan to which you are eligible as of February 22, 2018.

Effective Date of this Decision: April 26, 2018

How this Decision Affects Your Eligibility

This is not your final determination. You will receive a new eligibility determination based on four-person household in New York County, with an annual household income of $36,400.01, as of February 22, 2018.

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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The February 23, 2018 eligibility determination notice is RESCINDED.

This is not your final determination. You will receive a new eligibility determination based on four-person household in New York County, with an annual household income of $36,400.01, as of February 22, 2018.

Once your eligibility is determined, NYSOH facilitate your enrollment in your new heath plan to which you are eligible as of February 22, 2018.

Legal Authority

We are issuing this determination in accordance with 45 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).

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).