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

Notice of Decision

Decision Date: May 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030108

[redacted]

Dear [redacted],

On May 14, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 5, 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).

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

Decision

Decision Date: May 21, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000030108

[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 $201.00 per month in advance payments of the premium tax credit (APTC)?
>
> Did NYSOH properly determine that you were ineligible for cost-sharing reductions (CSR)?
>
> Did NYSOH properly determine that you were ineligible for the Essential Plan?

Procedural History

On February 28, 2018, you submitted an application for financial assistance through NYSOH.

Also on February 28, 2018, you uploaded income documentation to your NYSOH account (*see* Document [redacted]

On March 1, 2018, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible to enroll in the Essential Plan with a $20.00 premium per month for a limited time, effective April 1, 2018. The notice instructed you to submit proof of income by May 29, 2018, to confirm your eligibility.

On March 4, 2018, your NYSOH account was systemically updated.

On March 5, 2018, NYSOH issued an eligibility determination notice stating, in relevant part, that you were eligible for a tax credit up to $201.00 per month, effective April 1, 2018. Further, the notice stated that you were ineligible for CSR and the Essential Plan because your income was over the allowable income limits for those programs.

On March 13, 2018, you spoke with NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance you were determined eligible to receive.

On April 20, 2018, you uploaded income documentation to your NYSOH account (*see* Documents [redacted] and [redacted]

On May 14, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was 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 were appealing only the amount of financial assistance that you were determined eligible to receive.

2) According to your February 28, 2018 application, you expect to file a 2018 federal income tax return with the tax status of Head of Household (with qualifying individual), and expect to claim your [redacted] as a dependent on that tax return.

3) You testified that you are employed at [redacted], and that is your only source of income.

4) On February 28, 2018, you submitted paystubs from [redacted] to NYSOH (*see* Document [redacted] The paystubs reflect that you were issued federal taxable income of:

    (a) $795.00 on February 2, 2018;

    (b) $795.00 on February 8, 2018;

    (c) $940.75 on February 16, 2018; and

    (d) $795.00 on February 22, 2018.

5) According to your NYSOH account, on March 4, 2018, your annual household income was calculated to be $43,234.75.

6) According to your NYSOH account, you do not expect to claim any deductions on your 2018 federal income tax return.

7) You testified that you want your dependent care expenses to be considered when your eligibility for financial assistance is determined.

8) You testified that your weekly income is inconsistent.

9) On April 20, 2018, you submitted paystubs from [redacted] to NYSOH (*see* Document [redacted]. The paystubs reflect that you were issued federal taxable income of:

    a) $715.50 on March 29, 2018;

    b) $897.50 on April 5, 2018;

    c) $397.50 on April 13, 2018; and

    d) $937.50 on April 19, 2018.

10) According to your NYSOH account, you reside in [redacted], New York.

11) You testified you are unable to afford the health insurance premiums based on the amount of financial assistance you were determined eligible to receive.

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

Applicable Law and Regulations

Income Verification

An applicant is required to attest to their household's projected annual income for purposes of determining their eligibility for APTC (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request

additional information from the applicant to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

Child and dependent care expense payments may be claimed on Line 49 of Form 1040; however, these expenses are not used to compute adjusted gross income (26 USC § 21; Internal Revenue Service (IRS) Publication 503 (2017)).

Household Composition

For APTC and CSR, the household size equals the number of individuals for whom the taxpayers are 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)).

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 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 in 2018 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 (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)).

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).

Affordability Exemption

Under some circumstances, a person may receive an exemption from paying a penalty for not purchasing health insurance coverage. Such an exemption may be granted if that person can show that he or she experienced a financial hardship or has domestic circumstances that (1) caused an unexpected increase in essential expenses that prevented that person from obtaining health coverage under a QHP; (2) would have caused the person to experience serious deprivation of food, shelter, clothing, or other necessities, as a result of the expense of purchasing health coverage under a QHP; or (3) prevented that person from obtaining coverage under a QHP (45 CFR § 155.605(a), (g)).

NY State of Health has deferred to the U.S. Department of Health and Human Services (HHS) on the matter of hardship exemptions (see 45 CFR § 155.505(c)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for up to $201.00 of APTC per month.

On February 28, 2018, you submitted an application for financial assistance through NYSOH. Based on that application, on March 1, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to enroll in the Essential Plan with a $20.00 premium per month for a limited time, effective April 1, 2018.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to their household's projected annual income. NYSOH must request income data from federal data sources to verify an individual's income attestation.

If NYSOH cannot verify an individual's attestation, it must provide the individual with notice of the inconsistency and provide a period of 90 days from the date notice is received to resolve the inconsistency.

The notice issued on March 1, 2018, advised you that your eligibility was only conditional, and that you needed to submit documentation to confirm your household's income by May 29, 2018.

On February 28, 2018, you submitted paystubs from [redacted] to NYSOH (Document [redacted] The paystubs reflect that you were issued federal taxable income of: $795.00 on February 2, 2018; $795.00 on February 8, 2018; $940.75 on February 16, 2018; and $795.00 on February 22, 2018. Based on that documentation, NYSOH calculated your annual household income calculated to be (($795.00 + $795.00 + $940.75 + $795.00) X 13 periods) $43,234.75.

For an individual who expects to file a federal income tax return, the household equals the taxpayers and the number of individuals for whom the taxpayer is claiming as a dependent.

You attested that you expect to file a 2018 federal income tax return with the tax status of Head of Household (with qualifying individual), and expect to claim your [redacted] child as a dependent on that tax return. Therefore, you were in a two-person household for purposes of this analysis.

You reside in [redacted], New York, where the second lowest cost silver plan available for an individual through NYSOH costs $509.30 per month.

An annual income of $43,234.75 is 266.22% of the 2017 FPL for a two-person household. At 266.22% of the 2017 FPL, the expected contribution is 8.57% of the household income, or $308.77 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 ($509.30 per month) minus your expected contribution ($308.77 per month), which equals $200.53 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $201.00 per month in APTC.

The second issue under review is whether you were properly found ineligible for CSR.

CSR are available to a person who has a household income no greater than 250% of the 2017 FPL. Since a two-person household with an income of $43,234.75 is 266.22% of the 2017 FPL, NYSOH correctly found you to be ineligible for CSR.

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

The Essential Plan is 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 $43,234.75 is 266.22% of the 2017 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Therefore, the March 5, 2018 eligibility determination is AFFIRMED.

You testified that you want your dependent care expenses to be considered when your financial assistance is determined; however, those expenses cannot be used when calculating your adjusted gross income. Therefore, they cannot be considered when your financial assistance is determined.

You testified that your weekly income is inconsistent. On April 20, 2018, you submitted paystubs from [redacted] to NYSOH (Document [redacted] The paystubs reflect that you were issued federal taxable income of: $715.50 on March 29, 2018; $897.50 on April 5, 2018; $397.50 on April 13, 2018; and $937.50 on April 19, 2018. Based on the documentation submitted, your annual household income is (($715.50 + $897.50 + $397.50 + $937.50) X 13 periods) $38,324.00.

Therefore, your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a two-person household, for an individual residing in [redacted] New York, with an annual household income of $38,324.00.

Decision

The March 5, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a two-person household, for an individual residing in [redacted], New York, with an annual household income of $38,324.00, and to notify you accordingly.

Effective Date of this Decision: May 21, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility for or enrollment in health insurance coverage through NYSOH.

Your case has been returned to NYSOH to redetermine your eligibility for financial assistance based on the parameters above. NYSOH will notify you of its redetermination.

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).

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
- 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

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Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The March 5, 2018 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a two-person household, for an individual residing in [redacted], New York, with an annual household income of $38,324.00, and to notify you accordingly.

This decision does not change your eligibility for or enrollment in health insurance coverage through NYSOH.

Your case has been returned to NYSOH to redetermine your eligibility for financial assistance based on the parameters above. NYSOH will notify you of its redetermination.

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).