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: AP000000030169

[redacted]

Dear [redacted]

On May 16, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's March 13, 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.

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: AP000000030169

[redacted]

Issue

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

> Did NY State of Health (NYSOH) properly determine that you and your spouse were eligible to receive up to $821.00 per month in advance payments of the premium tax credit, effective April 1, 2018?

Procedural History

On November 30, 2017, you applied for health insurance and financial assistance for yourself and your spouse through NYSOH.

On December 1, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible to enroll in the Essential Plan for a limited time, effective January 1, 2018. This notice directed you to submit documentation of your household income by February 28, 2018 in order to confirm your eligibility for financial assistance.

On December 1, 2017, NYSOH issued an enrollment confirmation notice stating that you and your spouse were enrolled in an Essential Plan, effective January 1, 2018.

On February 21, 2018, income documentation was uploaded to your NYSOH account.

Also on February 21, 2018, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On February 22, 2018, NYSOH issued a notice stating that the income documentation you submitted did not confirm the information in your application and that additional income documentation was required by March 15, 2018.

On March 2, 2018, additional income documentation was uploaded to your NYSOH account.

On March 5, 2018, NYSOH redetermined your and your spouse's eligibility for financial assistance.

On March 6, 2018, NYSOH issued a notice of eligibility determination stating that you and your spouse were eligible to enroll in the Essential Plan, effective April 1, 2018.

On March 12, 2018, additional income documentation was uploaded to your NYSOH account.

Also on March 12, 2018, NYSOH verified the income documentation you submitted, recalculated your household income based on this documentation, and submitted an updated application based on this recalculation.

On March 13, 2018, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $821.00 per month in advance payments of the premium tax credit (APTC) as well as cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective April 1, 2018. That notice also stated that you and your spouse were not eligible for the Essential Plan because your annual household income was over the allowable income limit for that program.

Also on March 13, 2018, NYSOH issued a disenrollment notice stating that your and your spouse's coverage in your Essential Plan would end on March 31, 2018. This was because you and your spouse were no longer eligible to enroll in the Essential Plan.

On March 14, 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 March 20, 2018, NYSOH issued a notice stating that you and your spouse were eligible for the Essential Plan for a limited time, effective April 1, 2018. This was because you and your spouse had been granted Aid to Continue pending the outcome of your appeal.

On March 20, 2018, NYSOH issued an enrollment confirmation notice stating that you and your spouse were enrolled in the Essential Plan, effective April 1, 2018.

On May 16, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. 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 and your spouse expect to file your tax return for 2018 with a tax filing status of married filing jointly. You will not claim any dependents on that return.

2) You are seeking insurance for yourself and your spouse.

3) The application that was submitted on November 30, 2017 listed annual household income of $25,584.00, consisting of $201.00 per week for a yearly total of $10,452.00 you expect to earn from your employment and $15,132.00 your spouse expects to earn from employment.

4) On February 21, 2018, you submitted three of your paystubs; the first is for pay date February 2, 2018 for a gross pay amount of $279.75; the second is for pay date February 9, 2018 for a gross pay amount of $271.43; the third is for pay date February 16, 2018 for a gross pay amount of $174.81.

5) Also on February 21, 2018, you submitted four of your spouse's paystubs; the first is for pay date January 26, 2018 for a gross pay amount of $312.00; the second is for pay date February 2, 2018 for a gross pay amount of $312.00; the third is for pay date February 9, 2018 for a gross pay amount of $312.00; the fourth is for pay date February 16, 2018 for a gross pay amount of $312.00.

6) On February 21, 2018, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account as you had only submitted three paystubs for yourself and four paystubs were required.

7) On March 2, 2018, you uploaded two additional paystubs to your NYSOH account; the first is for pay date February 23, 2018 for a gross pay amount

of $174.86; the second is for pay date March 2, 2018 for a gross pay amount of $166.65.

8) On March 12, 2018, you uploaded three additional paystubs for your spouse to your NYSOH account; the first is for pay date February 23, 2018 for a gross pay amount of $416.00; the second is for pay date March 2, 2018 for a gross pay amount of $340.52; the third is for pay date March 9, 2018 for a gross pay amount of $325.33.

9) On March 12, 2018, NYSOH recalculated your spouse's annual expected income to be $26,150.30. That day, NYSOH updated the annual expected income for your household to be $36,602.30, consisting of $10,452.00 from your wages and $26,150.30 from your spouse's wages.

10) The eligibility determination issued on March 13, 2018 was based on a household of two with an annual expected household income of $36,602.30.

11) You testified that you have one employer. You explained that your pay varies from week to week based on a number of factors, however, you stated that your annual expected income remains approximately $10,452.00.

12) You testified that your spouse has only one employer. You explained that he typically makes $312.00 per week, however, he does make more in some weeks due to additional hours worked or when he travels for work.

13) You testified that the paystubs you submitted for yourself and your spouse were an accurate representation of your and your spouse's earnings.

14) You testified that you are seeking to be found eligible for the Essential Plan.

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

16) Your application states, and you confirmed, that you live in Erie County.

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 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).

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 issue is whether NYSOH properly determined that you and your spouse eligible for up to $821.00 per month in APTC.

You and your spouse expect to file your 2018 income tax return as married filing jointly and you will not claim any dependents on that tax return. Therefore, you and your spouse are in a two-person household.

The application that you submitted on November 30, 2017 listed annual household income of $25,584.00. Following submission of this application, NYSOH requested that you submit documentation of your household income.

As of March 12, 2018, you had submitted five consecutive paystubs for yourself and seven consecutive paystubs for your spouse.

On March 12, 2018, NYSOH verified these paystubs as satisfactory documentation of your income and an application for financial assistance was run on your behalf by an NYSOH representative. The NYSOH representative entered into your application earned income for your spouse of $26,150.30 and left your income unchanged, for household income of $36,602.30.

It is entirely unclear from the record how NYSOH calculated your spouse's annual earned income to be $26,150.30. NYSOH has provided no explanation for how your spouse's annual expected income was calculated to be $26,150.30.

As the income amount that was relied upon in the March 13, 2018 eligibility determination notice is not supported by the record, the eligibility determination is RESCINDED.

The paystubs you submitted show that your and your spouse's annual expected income for your household is $28,360.80 (the last four paystubs you submitted yield a four week gross of $787.75 and a weekly average of $196.94 multiplied by 52 for a gross income of $10,240.75) (the last four paystubs your spouse submitted yield a four week gross of $1,393.85 and a weekly average of $348.46 multiplied by 52 for a gross income of $18,120.05).

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance as of March 13, 2018 based on a household of two with annual expected income of $28,360.80, residing in Erie County, and to permit you and your spouse to select a plan for enrollment as though your eligibility had been properly determined on March 13, 2018.

Decision

The March 13, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance as of March 13, 2018 based on a household of two with annual expected income of $28,360.80 residing in Erie County, and to permit you and your spouse to select a plan for enrollment as though your eligibility had been properly determined on March 13, 2018.

Effective Date of this Decision: May 21, 2018

How this Decision Affects Your Eligibility

This is not a final determination of your and your spouse's eligibility.

Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility for financial assistance based on the income documentation you submitted.

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 March 13, 2018 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your and your spouse's eligibility for financial assistance as of March 13, 2018 based on a household of two with annual expected income of $28,360.80 residing in Erie County, and to permit you and your spouse to select a plan for enrollment as though your eligibility had been properly determined on March 13, 2018.

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 is not a final determination of your and your spouse's eligibility.

Your case is being sent back to NYSOH to redetermine your and your spouse's eligibility for financial assistance based on the income documentation you submitted.

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).