



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

## Notice of Decision

Decision Date: March 30, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013136

[REDACTED]

Dear [REDACTED]

On February 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 9, 2016 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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## Decision

Decision Date: March 30, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013136

[REDACTED]

[REDACTED]

## Issues

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

Did NY State of Health properly determine that you were eligible to receive up to \$220.00 per month in advance payments of the premium tax credit and eligible for cost-sharing reductions, effective December 1, 2016?

Did NY State of Health properly determine that you were not eligible for the Essential Plan?

## Procedural History

On November 8, 2016, NY State of Health (NYSOH) received your completed application for health insurance. That day, a preliminary eligibility determination was prepared finding you eligible for advance premium tax credits (APTC) of \$220.00 per month and eligible for cost sharing reductions if you enrolled in a silver-level qualified health plan, both effective December 1, 2016.

Also on November 8, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of that preliminary eligibility determination insofar as you were eligible for APTC and not the Essential Plan.

On November 9, 2016, NYSOH issued an eligibility redetermination notice based on the information contained in the November 8, 2016 application, stating that you were eligible to receive APTC of up to \$220.00 per month and that you were eligible for cost-sharing reductions, effective December 1, 2016.

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On February 14, 2017, 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 expect to file your 2016 taxes with a tax filing status of single. You will claim no dependents on that tax return.
- 2) You are seeking insurance for yourself.
- 3) The application that was submitted on November 8, 2016 listed annual household income of \$25,500.00. You testified that that amount was correct at the time.
- 4) You testified that you earn your income working as an independent contractor; that is as a [REDACTED] serving individual clients. You testified that your income is about \$2,000.00 a month and varies depending on number of sessions and clients that you see. You testified that a better estimate of your income would be about \$24,000.00 a year.
- 5) You testified that your income for this year will probably be the same as last year.
- 6) Your application states that you will not be taking any deductions on your 2016 tax return.
- 7) You testified that you are appealing because you want to be eligible for the Essential Plan, as you feel that the cost of health coverage with the level of APTC and CSR you were found eligible for is not affordable with the high cost of living in [REDACTED] and with your budget.
- 8) Per your NYSOH account and your testimony, you live in [REDACTED] County, New York.

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

## **Applicable Law and Regulations**

### 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 funds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

“Adjusted gross income” is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, interest on a qualified educational loan can be deducted from adjusted gross income in an amount up to \$2,500 in interest paid by taxpayers during the taxable year, whose yearly income does not exceed \$160,000 (26 USC § 221; see also 26 USC § 62 (17)).

### 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*

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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 2016 is set by federal law at 2.03% to 9.66% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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 2015 FPL, which is \$11,770.00 for a one-person household (80 Federal Register 3236, 3237).

For annual household income in the range of at least 200% but less than 250% of the 2015 FPL, the expected contribution in 2016 is between 6.41% and 8.18% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2014-37, IRS Rev. Proc. 2014-62).

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

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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), N.Y. Soc. Serv. Law § 369-gg(3), 42 USC § 18051).

In an analysis of Essential Plan eligibility, the determination is based on the FPL for 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 2015 FPL, which is \$11,770.00 for a one-person household (80 Fed. Reg. 3236, 3237).

### 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)).

NYSOH 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 is whether NYSOH properly determined that you were eligible for an APTC of up to \$220.00 per month, effective December 1, 2016.

The application that was submitted on November 8, 2016 listed an annual household income of \$25,500.00 and the eligibility determination relied upon that information. During the hearing, you testified that you live in [REDACTED] and have very high living expenses such as rent, utilities and food. You testified that there is no room in your budget for health insurance and plans are not affordable even with the monthly APTC. Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, and other living expenses to be deducted from the calculation of your adjusted gross income, they cannot be deducted when NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, the household income amount of \$25,500.00 that was used in calculating your eligibility for APTC was correct.

You are in a one-person household for purposes of this analysis. This is because you expect to file your 2016 income taxes as single and will claim no dependents on that tax return.

You reside in [REDACTED] County, where the second lowest cost silver plan available for an individual through NYSOH costs \$368.26 per month.

An annual income of \$25,500.00 is 216.65% of the 2015 FPL for a one-person household. At 216.65% of the FPL, the expected contribution to the cost of the health insurance premium is 6.99% of income, or \$148.74 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 (\$368.26 per month) minus your expected contribution (\$148.74 per month), which equals \$219.52 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$220.00 per month in APTC.

The second issue is whether you were properly found 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 \$25,500 is 216.65% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue 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 (MAGI) that is between 138% and 200% of the Federal Poverty Level (FPL) for the applicable family size. On the date of your application, the relevant FPL was \$11,770.00 for a one-person household. Since an annual household income of \$25,500.00 is 216.65% of the 2015 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the November 9, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to \$220.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

You testified that it would be a financial hardship and you cannot afford to pay for health insurance, which may qualify you for a hardship exemption. If you wish to be considered for a hardship exemption, which would exempt you from paying a penalty for not having health insurance during 2016 or 2017, you can check the Federal Marketplace website ([www.healthcare.gov](http://www.healthcare.gov)) for direction.

## **Decision**

The November 9, 2016 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** March 30, 2017

### **How this Decision Affects Your Eligibility**

You were eligible for up to \$220.00 per month in APTC during December 2016.

You were eligible for cost-sharing reductions during December 2016.

You were ineligible for the Essential Plan as of the November 9, 2016 eligibility determination notice.

### **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

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 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 November 9, 2016 eligibility determination notice is AFFIRMED.

You were eligible for up to \$220.00 per month in APTC during December 2016.

You were eligible for cost-sharing reductions during December 2016.

You were ineligible for the Essential Plan as of the November 9, 2016 eligibility determination notice.

If you wish to be considered for a hardship exemption, which would exempt you from paying a penalty for not having health insurance during 2016 or 2017, you can check the Federal Marketplace website ([www.healthcare.gov](http://www.healthcare.gov)) for direction.

## **Legal Authority**

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

[REDACTED]

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## **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. يمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجاناً.

### **বাংলা (Bengali)**

এটি এক গুরুত্বপূর্ণ নথি। এটি বুজতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূলে আমরা আপনাকে একজন দোভাসী 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 ब्रुङ्ग 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 nkyerɛkyeremu a, ye sre 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 مستاویز 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)

דא איז א וויכטיגער דאקטומענט. אויב איר דארפֿט הילפֿ עס צו פֿאָרְשֶׁטִין, בִּיטָּע רּוֹפְּטַן 1-855-355-5777. מִיר קָעָנוּן אַיִ' גַּעַבְּן אַדְלָמְעַטְשֶׁר פֿרִי פֿוֹן אַפְּצָאַל אַיִ' שְׁפָרָאַךְ וְאַוְ אַיִ' רַעַדְטַן.