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

Notice of Decision

Decision Date: March 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013147

[redacted]

Dear [redacted]

On February 17, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 26, 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).

This page intentionally left blank.

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

Decision

Decision Date: March 24, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000013147

[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 $173.00 per month in advance payments of the premium tax credit (APTC), effective December 1, 2016?
>
> Did NYSOH properly determine that you were eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you were not eligible for the Essential Plan?
>
> Did NYSOH properly determine that you were not eligible for Medicaid?

Procedural History

On September 9, 2016, you updated your NYSOH application for financial assistance with health insurance.

On September 10, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan, with a $20.00 monthly premium, for a limited time, effective October 1, 2016. The notice further directed you to submit documentation of your income by December 8, 2016, or you might lose your insurance or receive less financial assistance.

Also on September 10, 2016, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan, effective October 1, 2016.

On September 14 and October 15, 2016, you uploaded documentation to your NYSOH account.

On October 25, 2016, NYSOH redetermined your eligibility.

On October 26, 2016, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $173.00 per month in APTC, and eligible for cost-sharing reductions, effective December 1, 2016.

Also on October 26, 2016, NYSOH issued a disenrollment notice stating that your enrollment in your Essential Plan coverage was discontinued effective November 30, 2016 because you were no longer eligible to remain enrolled in your current health insurance.

On November 8, 2016, you contacted NYSOH's Account Review Unit and requested an appeal of the October 26, 2016 eligibility determination, insofar as you were found eligible for APTC and not the Essential Plan. You also requested Aid to Continue, pending the outcome of your appeal.

On November 23, 2016, NYSOH issued an eligibility determination stating that you were eligible for the Essential Plan, with a $20.00 monthly premium for a limited time, effective December 1, 2016. This was because you had been granted Aid to Continue, pending the outcome of your appeal.

Also on November 23, 2016, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan, effective December 1, 2016. This was also pursuant to your request for Aid to Continue.

On February 17, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and kept open for fifteen days at the end of the hearing to allow you time to submit your 2016 W2s, and documentation of your income for the month of December 2016.

On March 4, 2017, you uploaded eight documents to your NYSOH account. No further documentation was submitted. The record is now closed.

Findings of Fact

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

1) You testified that you expect to file your 2016 and 2017 taxes with a tax filing status of single. You will claim no dependents on either tax return.

2) NYSOH determined that your expected annual income for 2016 was $29,088.00, consisting of income you earn from employment.

3) You testified that your 2016 income was about $31,000.00, based on the 2016 W2's that you received.

4) You testified that you have one job, but are paid by five different entities, and receive a total of two paychecks bi-weekly.

5) You testified that your income is based on a daily rate.

6) You testified that you believe your 2017 income will be approximately the same.

7) You testified that you believe your income for December 2016 was approximately $2,800.00, but might have been a little less because you took off the week of Christmas.

8) After the hearing, you uploaded eight documents to your NYSOH account as follows:

    a. A 2016 W2 from [redacted] showing gross earnings of $6,905.00;
    b. A 2016 W2 from [redacted] showing gross earnings of $1,600.00;
    c. A 2016 W2 from [redacted] showing gross earnings of $1,800.00;
    d. A 2016 W2 from [redacted] showing gross earnings of $11,411.50;
    e. A 2016 W2 from [redacted] showing gross earnings of $9,800.00;
    f. Two paystubs for December 2, 2016 showing gross earnings of $400.00 and $800.00;
    g. Two paystubs for December 16, 2016 showing gross earnings of $800.00 and $600.00;
    h. Two paystubs for December 30, 2016 showing gross earnings of $600.00 and $800.00.

    These documents are collectively marked and entered into the record as "Appellant's Exhibit One."

9) Your application states that you will not be taking any deductions on your 2016 tax return, and you testified that you do not expect to take any on your 2017 tax return, either.

10) Your application states that you live in [redacted] County.

11) You testified that the cost of living in [redacted] is very expensive, and that you cannot afford to pay for a health plan, so you are looking to be eligible for the Essential Plan.

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

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/basic-health-program.html).

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).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).

In an analysis of Medicaid eligibility, the determination is based on the FPL "for the applicable budget period used to determine an individual's eligibility" (42 CFR § 435.4). On the date of your application, that was the 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income.

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible to receive APTC of up to $173.00 per month.

NYSOH determined your expected annual household income for 2016 to be $29,088.00, and the eligibility determination relied upon that information.

During the hearing, you testified that this amount was approximately correct. However, you asked that your current expenses, which include rent and other living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable and phone 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, NYSOH correctly determined your household income to be $29,088.00.

You are in a one-person household. 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 subscriber through NYSOH costs $368.26 per month.

An annual income of $29,088.00 is 247.13% of the 2015 FPL for a one-person household. At 247.13% of the FPL, the expected contribution to the cost of the health insurance premium is 8.08% of income, or $195.86 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 subscriber in your county ($368.26 per month) minus your expected contribution ($195.86 per month), which equals $172.40 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $173.00 per month in APTC.

The second issue under review 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 $29,088.00 is 247.13% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

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 MAGI that is between 138% and

200% of the 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 $29,088.00 is 247.13% of the 2015 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth issue is under review is whether NYSOH properly determined that you were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $11,880.00 for a one-person household. Since $29,088.00 is 244.85% of the 2015 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You submitted documentation after the hearing that shows you received a total of $4,000.00 in gross income in the month of December 2016 (Appellant's Exhibit One).

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,366.20 per month. Since the documentation you provided shows that you earned $4,000.00 in December 2016, you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the October 26, 2016 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $173.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid, it is correct and is AFFIRMED.

During the hearing, you also requested to have your eligibility reviewed for 2017. Since your 2016 eligibility for APTC expired on December 31, 2016, and since you have been waiting for a decision from this appeal, your case is RETURNED to NYSOH to determine your eligibility for financial assistance for 2017, based on a household of one, with an expected annual income of $31,000.00, residing in [redacted] County.

Decision

The October 26, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to determine your eligibility for financial assistance for 2017, based on a household of one with an annual expected income of $31,000.00 residing in [redacted] County.

Effective Date of this Decision: March 24, 2017

How this Decision Affects Your Eligibility

You were eligible for up to $173.00 in APTC during the month of December 2016.

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

You are ineligible for the Essential Plan.

You are ineligible for Medicaid.

NYSOH will review your eligibility for financial assistance for 2017 and will notify you of its decision in writing.

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
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The October 26, 2016 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to determine your eligibility for financial assistance for 2017, based on a household of one with an annual expected income of $31,000.00 residing in [redacted] County.

You were eligible for up to $173.00 in APTC and cost-sharing reductions during the month of December 2016.

You are ineligible for the Essential Plan and ineligible for Medicaid.

NYSOH will review your eligibility for financial assistance for 2017 and will notify you of its decision in writing.

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).

Legal Authority

We are sending you this notice 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 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.

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).