



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

## Notice of Decision

Decision Date: April 28, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013991

[REDACTED]

Dear [REDACTED]

On March 20, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's November 17, 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.

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## Decision

Decision Date: April 28, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000013991



## 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 \$223.00 per month in advance payments of the premium tax credit, effective January 1, 2017?

Did NY State of Health properly determine that you were eligible for cost-sharing reductions?

Did NY State of Health properly determine that you were not eligible for Medicaid?

## Procedural History

On November 16, 2016, NY State of Health received your application for financial assistance with health insurance for 2017.

On November 17, 2016, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$223.00 in advanced premium tax credits (APTC) and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective January 1, 2017. That notice also stated that you were not eligible for Medicaid because your household income was over the allowable income limit for that program.

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On December 13, 2016, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination notice insofar as you are seeking a greater amount of APTC or to be found eligible for Medicaid.

On March 20, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and 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 expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.
- 2) You are seeking insurance for yourself.
- 3) The application that was submitted on November 16, 2016 listed annual household income of \$38,949.44, consisting of \$13,392.00 you receive from your Social Security benefits, \$4,000 you receive from your IRA distributions, \$11,424.00 your spouse receives from his Social Security benefits, \$4,000.00 he receives from his IRA distributions, and \$6,133.44 he receives from his pension and annuity payments.
- 4) You testified that your household income amount was incorrect because your personal income only consists of your Social Security benefits.
- 5) The system calculated your monthly household income to be \$3,245.78.
- 6) Your application states that you will not be taking any deductions on your 2017 tax return.
- 7) Your application states that you live in [REDACTED].
- 8) You testified that you have household expenses, including a high tax payment and electric bill that you think should be deducted from your household income.
- 9) You further testified that you cannot afford a high health insurance premium payment and that you would like to be found eligible for a greater amount of APTC or Medicaid.

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

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 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

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 2016 FPL, which is \$16,020.00 for a two-person household (81 Fed. Reg. 4036.).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution in 2017 is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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

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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)).

### 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 \$16,020.00 for a two-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

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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 taxes and utilities are not an allowable deduction in computing adjusted gross income.

### 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 under review is whether NYSOH properly determined that you were eligible for APTC of up to \$223.00 per month.

You testified that your income only consists of \$13,392.00 you receive in Social Security Benefits, and that you do not receive any IRA distributions.

However, the application that was submitted on November 17, 2016 listed an annual household income of \$38,949.44 consisting of \$13,392.00 you receive from your Social Security benefits, \$4,000 you receive from your IRA distributions, \$11,424.00 your spouse receives from his Social Security benefits, \$4,000.00 he receives from his IRA distributions, and \$6,133.44 he receives from his pension and annuity payments and the eligibility determination relied upon that information.

During the hearing, you asked that your current expenses, which include a high tax payment, electric bill 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 utilities or tax payments to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, NYSOH correctly determined your household income to be \$38,949.44.

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You are in a two-person household. You expect to file your 2017 income taxes as married filing jointly and will claim no dependents on that tax return.

You reside in [REDACTED], where the second lowest cost silver plan available for an individual through NYSOH costs \$481.04 per month.

An annual income of \$38,949.44 is 243.13% of the 2016 FPL for a two-person household. At 243.13% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 7.96% of income, or \$258.36 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 (\$481.04 per month) minus your expected contribution (\$258.36 per month), which equals \$222.68 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$223.00 per month in APTC.

The second issue under review is whether you were properly determined 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 \$38,949.44 is 243.13% 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 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 that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was \$16,020.00 for a two-person household. Since \$38,949.44 is 243.13% of the 2016 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

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

Your November 16, 2016 application states that your expected annual household income is 38,949.44 and the eligibility determination relied upon that information. Using the information you provided into your November 16, 2016 application, the system calculated a monthly household income of \$3,245.78.



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 \$1,843.00 per month for a two-person household. Since the system calculated your monthly income to be \$3,245.78, you do not qualify for Medicaid on the basis of monthly income as of the date of your application.

Since the November 17, 2016 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$223.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for Medicaid, it is correct and is AFFIRMED.

You testified that you cannot afford to pay for health insurance even with subsidies, which may qualify you for an 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 2017, you can check the Federal Marketplace website ([www.healthcare.gov](http://www.healthcare.gov)) for direction.

## **Decision**

The November 17, 2016 eligibility determination notice is AFFIRMED.

This Decision has no effect on any subsequent eligibility determinations made by NYSOH.

**Effective Date of this Decision:** April 28, 2017

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

You were properly found eligible for up to \$223.00 per month in APTC.

You were properly found eligible for cost-sharing reductions.

You were properly found ineligible for Medicaid because your household income for a household of two people is over the allowable limits for this program.

## **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

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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 November 17, 2016 eligibility determination notice is **AFFIRMED**.

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You were properly found eligible for up to \$223.00 per month in APTC.

You were properly found eligible for cost-sharing reductions.

You were properly found ineligible for Medicaid because your household income for a household of two people is over the allowable limits for this program.

This Decision has no effect on any subsequent eligibility determinations made by NYOSH.

### **Legal Authority**

We are sending you this notice in accordance with 45 CFR § 155.545.

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



## 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)

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### 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 مجاناً.

### 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।

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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 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye b&etumi ama wo obi a okyer& kasa a woka no ase ama wo kwa a wontua hwee.

## **(Urdu) اردو**

یہ ایک اہم دستاویز 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)**

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.

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