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

# Notice of Decision

Decision Date: June 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014746

Dear [redacted],

On May 11, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's January 11, 2017 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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nystateofhealth
The Official Health Plan Marketplace

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

## Decision

Decision Date: June 2, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000014746

## 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 $323.00 per month in advance payments of the premium tax credit, effective February 1, 2017?
>
> 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?

## Procedural History

On January 10, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared finding you eligible to receive up to $323.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective February 1, 2017.

Also on January 10, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your Essential Plan as of February 1, 2017.

On January 11, 2017, NYSOH issued an eligibility determination notice, based on the January 10, 2017 application, stating that you were eligible to receive up to $323.00 in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver-level qualified health plan, for a limited time, effective February 1,

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2017. That notice also stated that you were not eligible for the Essential Plan because your income was over the allowable income limits for that program.

On January 13, 2017 and April 4, 2017, NYSOH issued two eligibility determination notices, both stating that you were eligible for the Essential Plan in the form of Aid to Continue, effective February 1, 2017 and again April 1, 2017.

On May 11, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to May 26, 2017, to allow you to submit supporting documents.

On May 26, 2017, you submitted your 2016 corporate tax return and 2016 personal income tax return, along with all schedules and forms. These documents were made part of the record as "Appellant's Exhibit A." No further documentation was received and the record was closed that day.

## Findings of Fact

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

1) You initially testified that you expect to file your 2017 taxes with a tax filing status of head of household, but that you will claim no dependents on your tax return. You then retracted that statement and stated that your accountant does your tax return so you are not sure what your filing status is. You testified that your adult child resides with you, but files her own income taxes.

2) You are seeking insurance for yourself.

3) The application that was submitted on January 10, 2017 listed annual household income of $24,000.00 in gross earnings from your self-employment. You testified that this amount does not include your business expense deductions.

4) You testified that you expect your income for 2017 to decrease because you lost several clients.

5) On May 26, 2017, you submitted your 2016 corporate tax return and 2016 personal income tax return, along with all schedules and forms. These documents show that you file head of household and do not claim your adult child as a dependent (*see* Appellant's Exhibit A, p. 30).

6) The documents submitted on May 26, 2017 further show that your adjusted gross household income for 2016 is $21,737.00 consisting of

$24,682.00 in gross income you earn from self-employment less $2,945.00 in business expense deductions (*id*).

7) According to your NYSOH account and your testimony, you live in Suffolk County, New York.

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 $11,880.00 for a one-person household (81 Fed. Reg. 4036).

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For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution 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 who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

Cost-Sharing Reductions

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (*see* 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

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 2016 FPL, which is $11,880.00 for a one-person household (81 Fed. Reg. 4036).

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).

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)).

<u>Modified Adjusted Gross Income</u>

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.

<u>Business Expenses Deduction</u>

"Adjusted gross income" is the gross income of the taxpayer minus the deductions permitted (26 USC § 62). Subject to some limitations, deductions that are attributable to a trade or business may be deductions from a taxpayer's adjusted gross income (26 USC § 62 (a)(1)).

## Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $323.00 per month.

The application that was submitted on January 10, 2017 listed an annual household income of $24,000.00 and the eligibility determination relied upon that information.

According to your NYSOH account and the documents you submitted, you expect to file your 2017 income taxes as head of household and will claim no

dependents on that tax return. Therefore, you are in a one-person household for purposes of this analysis.

You reside in Suffolk County, where the second lowest cost silver plan available for an individual through NYSOH costs $453.36 per month.

An annual income of $24,000.00 is 202.02% of the 2016 FPL for a one-person household. At 202.02% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 6.5% of income, or $130.00 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 ($453.36 per month) minus your expected contribution ($130.00 per month), which equals $323.36 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $323.00 per month in APTC, based on the income information you provided in your application.

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 $24,000.00 is 202.02% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

Since the January 11, 2017 eligibility determination notice properly stated in part that you were eligible for an advance payment of the premium tax credit in an amount of up to $323.00 per month and eligible for cost sharing reductions, effective February 1, 2017, it is correct and must be AFFIRMED.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan, effective February 1, 2017.

The application that was submitted on January 10, 2017 listed annual household income of $24,000.00, consisting of $24,000.00 you earned from your self-employment in 2016. NYSOH relied on this information.

The Essential Plan is provided through NYSOH to individuals who meet the nonfinancial requirements and have a household modified adjusted gross income (MAGI) that is between 138% and 200% of the FPL for the applicable family size. The applicable FPL at the time of your January 10, 2017 application was $11,880.00 for a one-person household.

Since a household income of $24,000.00 is 202.02% of the applicable FPL for a one-person household, NYSOH properly found you to be ineligible for the

Essential Plan, based on the income information you provided. Therefore, the January 11, 2017 eligibility determination notice was correct and must be AFFIRMED in this regard as well.

However, you credibly testified, and submitted documentation to prove, that the income listed in your application did not include your business expense deductions. Your submitted 2016 personal income tax return shows that in 2016 you received $21,737.00 in adjusted gross household income, consisting of $24,682.00 in gross income you earn from self-employment less $2,945.00 in business expense deductions. You testified that this amount is a bit higher than what you expect to earn in 2017, due to a loss of several clients.

Since the record now contains a more accurate representation of your 2017 expected adjusted gross annual household income of $21,737.00, your case is RETURNED to NYSOH to re-determine your eligibility for financial assistance in 2017 based on a household income of $21,737.00 per year and a household size of one, for an individual residing in Suffolk County.

## Decision

The January 11, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to re-determine your eligibility for financial assistance in 2017 based on an annual household income of $21,737.00 and a one-person household, for an individual residing in Suffolk County.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

## Effective Date of this Decision: June 2, 2017

## How this Decision Affects Your Eligibility

This is not a final determination of your eligibility. While your eligibility for financial assistance was based on your attestation of income and, therefore was correct as of your January 10, 2017 application, your case is being sent back to NYSOH to re-determine your eligibility for financial assistance in 2017 based on an annual household income of $21,737.00 per year and a household size of one, for an individual residing in Suffolk County.

At present, you have Essential Plan coverage as of February 1, 2017 as Aid to Continue during the appeal process. Your enrollment will not be disturbed until

your eligibility is re-determined by NYSOH. NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

## 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 January 11, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to re-determine your eligibility for financial assistance in 2017 based on an annual household income of $21,737.00 and a one-person household, for an individual residing in Suffolk County.

NYSOH is directed to notify you of its redetermination and what further action may be required on your part, if applicable.

This is not a final determination of your eligibility. While your eligibility for financial assistance was based on your attestation of income and, therefore was correct as of your January 10, 2017 application, your case is being sent back to NYSOH to re-determine your eligibility for financial assistance in 2017 based on an annual household income of $21,737.00 per year and a household size of one, for an individual residing in Suffolk County.

At present, you have Essential Plan coverage as of February 1, 2017 as Aid to Continue during the appeal process. Your enrollment will not be disturbed until your eligibility is re-determined by NYSOH. NYSOH will notify you once this has been done and what further action may be required on your part, if applicable.

## 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:

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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. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

**□□□□□ (Bengali)**

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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 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.

**(Urdu)اردو**

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)**

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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).