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

Notice of Decision

Decision Date: September 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017460

[redacted]

Dear [redacted],

On September 8, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 9, 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.

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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).

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

Decision

Decision Date: September 13, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000017460

[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 $124.00 per month in advance payments of the premium tax credit (APTC)?
>
> Did NYSOH properly determine you ineligible for cost-sharing reductions (CSR)?
>
> Did NYSOH properly determine that you were ineligible for Medicaid?

Procedural History

On December 7, 2016, you submitted an application for financial assistance through NYSOH.

On December 8, 2016, NYSOH issued a notice stating that your application for health insurance had been received, but the income information in your application did not match what NYSOH received from state and federal data sources. The notice instructed you to provide proof of your household's income by December 18, 2016 and December 22, 2016.

On December 23, 2016, the documentation that was faxed to NYSOH was uploaded to your account (*see* Documents [redacted]).

On January 14, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice instructed you to provide proof of your household's income by January 21, 2017 and February 1, 2017.

On January 28, 2017, the documentation that was faxed to NYSOH was uploaded to your account (see Document [redacted]).

On February 8, 2017, NYSOH issued a notice stating that the documentation reviewed did not confirm the information in your application. The notice instructed you to provide proof of your household's income by March 3, 2017 and March 7, 2017.

On February 27, 2017, the documentation that was faxed to NYSOH was uploaded to your account (see Document [redacted]).

On March 8, 2017, your account was updated.

On March 9, 2017, NYSOH issued an eligibility determination notice stating in part that you were eligible for a tax credit up to $124.00 per month, effective April 1, 2017. The notice also stated that you were ineligible for CSR and Medicaid because your household income was over the allowable income thresholds for these programs.

On March 29, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as your ineligibility for Medicaid.

On July 11, 2017, you had a scheduled telephone hearing with a Hearing Officer from NYSOH's Appeals Unit; however, you did not appear for that hearing.

On July 14, 2017, NYSOH's Appeals Unit issued you a Notice of Dismissal for failing to appear for your scheduled telephone hearing (*see* Document [redacted]).

On September 7, 2017, you had a rescheduled 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 are appealing your eligibility for financial assistance and want to be found eligible for Medicaid.

2) According to your NYSOH account and testimony, your child was determined eligible to receive Child Health Plus. This finding is not in dispute.

3) According to your NYSOH account and testimony, you attested to filing your 2017 federal income tax return with the tax status of single and expect to claim your child as a dependent on that tax return.

4) You submitted paystubs from your employer showing you were issued gross income of:

    (a) $743.64 on January 5, 2017, with year-to-date (YTD) income of $743.64;
    (b) $1,076.02 on January 12, 2017, with YTD income of $1,819.66;
    (c) $876.22 on January 26, 2017, with YTD income of $3,410.94

   (*see* Document [redacted]).

5) According to your NYSOH account, on March 8, 2017, NYSOH calculated your annual household income to be $44,342.35.

6) You testified that you are paid on a weekly basis and work approximately 37 hours per week.

7) You testified that your wage rate is $22.86 per hour.

8) According to your account, you reside in [redacted], New York.

9) You testified that you are unable to afford health insurance because of your monthly expenses.

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 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.

Verification of Eligibility for Advance Payments of the Premium Tax Credit

An applicant is required to attest to their household's projected annual income for purposes of determining their eligibility for APTC (45 CFR § 155.320(c)(3)(ii)(B)). For all individuals, whose household income is needed, NYSOH must request tax return data from the Secretary of the Treasury and data regarding Social Security benefits from the Commissioner of Social Security in order to confirm that the information the applicant is attesting to is accurate (45 CFR § 155.320(c)(1)(i); 45 CFR § 155.320(c)(3)(ii)(A)).

If income data is unavailable, or if an applicant's attestation is not reasonably compatible with the income data NYSOH obtains, NYSOH must request additional information from the applicant in order to resolve the inconsistency (45 CFR § 155.320 (c)(3)(iii), (iv)).

Advance Payments of Premium Tax Credit

For purposes of APTC and CSR, the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (26 USC § 36B(d)(1)).

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 Federal Register 4036).

For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution in 2017 is between 8.21% and 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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 - Eligibility

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 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

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).

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 up to $124.00 per month in APTC.

A household is required to attest that to their household income. If the attestation is reasonably compatible with information obtained from available data sources, no further information or documentation is required. If the attestation is not reasonably compatible with information obtained from available data sources, documentation shall be required.

On December 7, 2016, you submitted an application through NYSOH. Based on that application, NYSOH issued a notice stating that the income information in your application did not match what NYSOH received from state and federal data sources. The notice instructed you to provide proof of your household income.

The record reflects that you submitted paystubs from your employer (*see* Document [redacted]). Based on that documentation, your projected household income was (($743.64 (+) $1,076.02 (+) $715.06 (+) 876.22) X 13) $44,342.22.

The update to your account on March 8, 2017 listed an annual household income of $44,342.35. Since there is an inconsequential difference between what NYSOH calculated your projected income to be and what your projected income should have been, this constitutes a de minims error.

During the hearing, you asked that your current monthly 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 the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, your household income applicable here is $44,342.35

When calculating family size for APTC, a household size consists of the taxpayer, his or her spouse, and any claimed dependents. You attested in that application that you expected to file your 2017 tax return, with the tax status of single, and expected to claim one dependent on that tax return. Therefore, you are in a two-person household for purposes of these analyses.

You reside in [redacted], where the second lowest cost silver plan for an individual through NYSOH costs $456.46 per month.

An annual income of $44,342.35 is 276.79% of the 2016 FPL for a two-person household. At 276.46% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 9.00% of income, or $332.57 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 ($456.46 per month) minus your expected contribution ($332.57 per month), which equals $123.89 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $124.00 per month in APTC.

The second issue under review is whether you were properly found eligible for CSR.

Cost-sharing reductions (CSR) are available to a person who has a household income no greater than 250% of the FPL. Since a two-person household with an income of $44,342.35 is 276.79% of the FPL, NYSOH correctly found you to be ineligible for CSR.

The third issue under review is whether NYSOH properly determined you 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 $16,240.00 for a two-person household.

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 $1,868.00 per month for a two-person household. There is nothing in your application to indicate you would not meet the non-financial criteria.

The record as of March 9, 2017, reflected that your household was being issued ($44,342.35 / 12 months) $3,695.20 per month. Therefore, your monthly income exceeded the maximum allowable monthly income amount of $1,868.00, and you did not qualify for Medicaid.

The March 9, 2017, eligibility determination notice properly determined you eligible for up to $124.00 of APTC per month and ineligible for CSR and Medicaid. Therefore, it is correct and AFFIRMED.

During the hearing, you testified that you work approximately 37 hours per week, and your wage rate is $22.86 per hour. Based on your testimony, your projected annual household income is ((37 hours X $22.86) X 52 weeks) $43,982.64. Since the income, you attested to will not materially change your eligibility for financial assistance, your case will not be returned to NYSOH to recalculate your eligibility.

Lastly, you testified that you cannot afford to pay for health insurance because of your monthly expenses. 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) for direction.

Decision

The March 9, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: September 13, 2017

How this Decision Affects Your Eligibility

You remain eligible for up to $124.00 per month of APTC.

You remain ineligible for CSR and Medicaid.

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

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: 1-855-900-5557

Summary

The March 9, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for up to $124.00 per month of APTC.

You remain ineligible for CSR and Medicaid.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

[redacted]

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Getting Help in a Language Other than English

This is an important document. If you need help to understand it, please call 1-855-355-5777. We can give you an interpreter for free in the language you speak.

Español (Spanish)

Este es un documento importante. Si necesita ayuda para entenderlo, llame al 1-855-355-5777. Le proporcionaremos un intérprete sin ningún costo.

中文 (Traditional Chinese)

這是重要的文件。 如果您需要獲得關於瞭解文件內容方面的協助，請致電 1-855-355-5777。我們可以為您免費提供您所使用語言的翻譯人員。

Kreyòl Ayisyen (Haitian Creole)

Sa a se yon dokiman ki enpòtan. Si ou bezwen èd pou konprann li, tanpri rele nimewo 1-855-355-5777. Nou kapab ba ou yon entèprèt gratis nan lang ou pale a.

中文 (Simplified Chinese)

这是一份重要的文件。如果您需要帮助理解此文件，请打电话至 1-855-355-5777。我们可以为您免费提供相应语种的口译服务。

Italiano (Italian)

Questo è un documento importante. Per qualsiasi chiarimento può chiamare il numero 1-855-355-5777. Possiamo metterle a disposizione un interprete nella sua lingua.

한국어 (Korean)

중요한 서류입니다. 이해하는 데 도움이 필요하시면 1-855-355-5777 번으로 연락해 주십시오. 귀하의 언어에 대한 무료 통역 서비스가 제공됩니다.

Русский (Russian)

Это важный документ. Если Вам нужна помощь для понимания этого документа, позвоните по телефону 1-855-355-5777. Мы можем бесплатно предоставить Вам переводчика Вашего языка.

العربية (Arabic)

هذه وثيقة مهمة. إذا كنت بحاجة إلى مساعدة لفهم محتواها، يُرجى الاتصال بالرقم 1-855-355-5777. يُمكننا توفير مترجم فوري لك باللغة التي تتحدثها مجانًا.

বাংলা (Bengali)

এটি এক গুরুত্বপূর্ণ নথি। এটি বুঝতে আপনার যদি সাহায্যের প্রয়োজন হয় তাহলে, অনুগ্রহ করে 1-855-355-5777 নম্বরে কল করুন। আপনি যে ভাষায় কথা বলেন বিনামূল্যে আমরা আপনাকে একজন দোভাষী দিতে পারি।

If you need this information in a language other than English or you need assistance reading this notice, we can help you. Call 1-855-355-5777 (TTY - English: 1-800-662-1220) (TTY – Spanish: 1-877-662-4886).

Français (French)

Ceci est un document important. Si vous avez besoin d'aide pour en comprendre le contenu, appelez le 1-855-355-5777. Nous pouvons mettre gratuitement à votre disposition un interprète dans votre langue.

हिंदी (Hindi)

यह एक महत्वपूर्ण दस्तावेज़ है। अगर आपको इसे समझने में सहायता चाहिए, तो कृपया 1-855-355-5777 पर कॉल करें। हम आपकी भाषा बोलने वाला एक दुभाषिया निःशुल्क उपलब्ध करवा सकते हैं।

日本語 (Japanese)

これは重要な書類です。理解するために支援が必要な場合は、1-855-355-5777 にお電話ください。通訳を無料で提供いたします。

नेपाली (Nepali)

यो एउटा महत्त्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई 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).