



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

Notice of Decision

Decision Date: August 9, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017604



Dear [REDACTED]

On July 14, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's March 14, 2017 eligibility determination.

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

Decision

Decision Date: August 9, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000017604



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 \$0.00 per month in advance payments of the premium tax credit, effective April 1, 2017?

Did NY State of Health properly determine that you were not eligible for cost-sharing reductions?

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

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

Procedural History

On February 10, 2017, NY State of Health (NYSOH) received your updated application for financial assistance.

On February 11, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to \$182.00 in advanced premium tax credits (APTC), for a limited time, effective March 1, 2017. That notice directed you to submit income documentation for yourself by May 11, 2017. That notice also stated that you were not eligible for the Essential Plan, or Medicaid because your income was over the allowable income limits for those programs.

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).

On February 28, 2017, you faxed income documentation to NYSOH which was uploaded to your account on March 3, 2017.

On March 13, 2017, NYSOH verified the income documentation, and ran an updated application for financial assistance with health insurance on your behalf.

On March 14, 2017, NYSOH issued an eligibility determination stating that you were eligible for \$0.00 per month in APTC, effective April 1, 2017.

On April 3, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not found eligible for more financial assistance with health insurance.

On July 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and the record was held open until July 31, 2017 to allow you time to submit supporting income documentation.

On July 27, 2017, NYSOH Appeal's Unit received two-page documentation from you. This income documentation was incorporated into the record as "Appellant's Exhibit #1", and the record was closed that same day.

Findings of Fact

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

- 1) You testified that you are only appealing your eligibility for financial assistance with health insurance.
- 2) You testified that you expect to file your 2017 taxes with a tax filing status of head of household and will be claiming one child as a dependent on that income tax return.
- 3) The application that was submitted on February 10, 2017 listed annual household income of \$38,948.01, consisting of income you earn from your employment.
- 4) On February 28, 2017, you faxed income documentation which contained two bi-weekly paystubs. The first paystub is dated February 10, 2017 for a gross income amount of \$2,224.72, and the second paystub is dated February 24, 2017 for a gross income amount of \$2,087.45.
- 5) On March 13, 2017, NYSOH validated your income documentation and updated your expected yearly income from \$38,948.01 to \$56,318.35.

- 6) You testified that the amount listed on your March 13, 2017 application was incorrect.
- 7) You testified that you worked overtime during the month of February 2017, and that you are not currently working overtime.
- 8) On July 27, 2017, you faxed a two-page document to the NYSOH's Appeals Unit containing two biweekly paystubs dated June 30, 2017 for a gross amount of \$1,422.89, and July 14, 2017 for a gross amount of \$1,838.62.
- 9) You testified that your oldest child moved back home with you, and he is currently not working.
- 10) Your application states, and you confirmed, that you will not be taking any deductions on your 2017 tax return.
- 11) Your application states, and you confirmed, that you live in [REDACTED].
- 12) You testified that you are unable to afford health insurance unless you receive more financial assistance.
- 13) You testified that you have bills including rent, cable, and car payment that you think should be deducted from your household income.

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 Federal Register 4036).

For annual household income in the range of at least 300% but less than 400% of the 2016 FPL, the expected contribution for 2017 is 9.69% 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

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).

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 \$16,020.00 for a two -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)).

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

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

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of \$0.00 per month.

The application that was submitted on February 10, 2017 listed an annual household income of \$38,948.01.

An individual requesting financial assistance to help pay for the cost of coverage provided through NYSOH is required to attest to their household’s projected annual income. For individuals seeking APTC, NYSOH must request income data from federal data sources in order to verify an individual’s income attestation.

If NYSOH cannot verify an individual’s attestation, it must provide the individual with notice of the inconsistency and provide a period of 90 days from the date notice is received to resolve the inconsistency.

In the eligibility determination issued on February 11, 2017, you were advised that your eligibility for APTC was only for a limited time, and that you needed to confirm your household’s income before May 11, 2017.

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).

You submitted income documentation on February 28, 2017. That income documentation consisted of two biweekly paystubs; which included a paystub dated February 10, 2017 for a gross amount of \$2,244.72 and a paystub dated February 24, 2017 for a gross amount of \$2,087.45. Using this income documentation you provided, NYSOH updated your expected annual income from \$38,948.01 to \$56,318.35 and an application was submitted on your household's behalf.

During the hearing, you testified that the amount of income that was listed in your March 13, 2017 application did not accurately depict what your income is. You testified that you worked overtime in February 2017, therefore, your monthly income was not accurately reflected through the income documentation you submitted. You further testified that you think your current expenses, which include rent, electricity, and other living expense should 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, NYSOH correctly determined your household income to be \$56,318.35 based on the income documentation you provided on February 28, 2017 and the eligibility determination relied upon that income.

As of the date of your March 13, 2017, your application stated that you were in a two-person household. You expect to file your 2017 income taxes as head of household and claim one child as a dependent on that tax return.

You reside in [REDACTED] where the second lowest cost silver plan available for an individual through NYSOH costs \$440.31 per month.

An annual income of \$56,318.35 is 351.55% of the 2017 FPL for a two-person household. At 351.55% of the FPL, the expected contribution to the cost of the health insurance premium is 9.69% of income, or \$454.77 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 (\$440.31 per month) minus your expected contribution (\$454.77 per month). Since your expected contribution exceeds the cost of the second lowest cost silver plan in your county, NYSOH properly determined that you were eligible for \$0.00 per month in APTC based on your March 13, 2017 application.

The second issue is whether you were properly found ineligible 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 \$56,318.35 is 351.55% of the applicable FPL, NYSOH properly found you to be ineligible 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 modified adjusted gross income that is between 138% and 200% 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 an annual household income of \$56,318.35 is 351.55% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth issue 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 \$16,240.00 for a two-person household. Since \$56,318.35 is 346.78% of the 2017 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.

The Hearing Officer left the record open until July 31, 2017 to allow you time to submit income documentation, including your income for the month of March 2017. However, by the end of the business day on July 31, 2017, NYSOH's Appeals Unit only received two paystubs from you dated June 30, 2017 and July 14, 2017. Therefore, the record does not contain any income documentation for the month of March 2017 and a decision cannot be made as to whether you would qualify for Medicaid on the basis of your monthly income.

Since the March 14, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for \$0.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is **AFFIRMED**.

Decision

The March 14, 2017 eligibility determination notice is AFFIRMED.

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

Effective Date of this Decision: August 9, 2017

How this Decision Affects Your Eligibility

NYSOH properly found you eligible for \$0.00 per month in APTC, effective April 1, 2017.

NYSOH properly found you ineligible for cost-sharing reductions.

NYSOH properly found you ineligible for the Essential Plan.

NYSOH properly found you ineligible for Medicaid.

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

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:

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 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 March 14, 2017 eligibility determination notice is **AFFIRMED**.

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

NYSOH properly found you eligible for \$0.00 per month in APTC, effective April 1, 2017.

NYSOH properly found you ineligible for cost-sharing reductions.

NYSOH properly found you ineligible for the Essential Plan.

NYSOH properly found you ineligible for Medicaid.

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Legal Authority

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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)

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)

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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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. y&b&tumi ama wo obi a okyerE 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.

שׂוֹדֵשׁ (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).