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: AP000000018120

[redacted]

Dear [redacted]

On July 18, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 12, 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: AP000000018120

[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 you were eligible to receive up to $174.00 per month in advance payments of the premium tax credit (APTC), effective May 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 17, 2017, you updated your application for financial assistance.

On January 18, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan with a $20.00 monthly premium for a limited time, effective February 1, 2017. The notice further directed you to submit documentation of your income by April 17, 2017.

Also on January 18, 2017, NYSOH issued a notice of enrollment confirmation confirming your enrollment in an Essential Plan, beginning March 1, 2016.

On January 19, 2017, you uploaded documentation to your NYSOH account.

On January 27, 2017, NYSOH issued a notice stating that the documentation you submitted was insufficient to confirm the information in your application. The notice directed you to submit documentation of your income by April 17, 2017.

On February 27, 2017, NYSOH uploaded documentation to your account that you mailed to NYSOH on February 2, 2017.

On March 9, 2017, NYSOH again issued a notice stating that the documentation you submitted was insufficient to confirm the information in your application. The notice directed you to submit documentation of your income by April 17, 2017.

On April 4, 2017, NYSOH uploaded documentation to your account that you mailed to NYSOH on March 29, 2017.

On April 11, 2017, NYSOH reran your application for financial assistance.

On April 12, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $174.00 per month in APTC, and eligible for cost-sharing reductions if you enrolled in a silver level QHP, effective May 1, 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.

Also on April 12, 2017, NYSOH issued a disenrollment notice stating that your enrollment in your Essential Plan 1 was ending, effective April 30, 2017, because you were no longer eligible to remain enrolled in the Essential Plan.

On April 18, 2017, you spoke to NYSOH's Account Review Unit and appealed the April 12, 2017 eligibility determination, insofar as you were not eligible for the Essential Plan. You also requested Aid to Continue, pending the outcome of your appeal.

On April 21, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan with a $20.00 monthly premium for a limited time, effective May 1, 2017. This was because you had been granted Aid to Continue, pending the outcome of your appeal.

Also on April 21, 2017, NYSOH issued a notice of enrollment confirmation, confirming your enrollment in an Essential Plan 1, beginning May 1, 2017, pursuant to your request for Aid to Continue.

On July 18, 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 through August 2, 2017, to allow you to submit supporting documents.

On July 22, 2017, NYSOH uploaded documentation to your NYSOH account that you mailed to NYSOH on July 19, 2017. The record is now closed.

## Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You testified that you will probably only claim your son as a dependent on that tax return.

2) You are seeking insurance for yourself only.

3) On March 29, 2017, you mailed four paystubs from your job to NYSOH, and NYSOH used these paystubs to calculate your expected annual income. The paystubs were for the following dates and amounts:

    a. March 2, 2017 - $500.25;
    b. March 9, 2017 - $468.63;
    c. March 16, 2017 - $448.50;
    d. March 23, 2017 - $460.00;
    (Document [redacted]).

4) NYSOH determined that your annual expected gross income for 2017 was $24,405.94. You indicated that your spouse's annual expected 2017 income was $26,136.00 in your January 17 2017 application, and NYSOH relied on this figure in its April 12, 2017 eligibility determination.

5) You testified that you work forty hours a week for $11.50 an hour.

6) You testified that your spouse earns $11.50 an hour as well, but that you were not sure how many hours she works each week.

7) You testified that your spouse's income is not always consistent because she works in [redacted], and may be out of work in the event of a [redacted].

8) Your application stated that you expect to claim two dependents on your 2017 income tax return.

9) You testified that your daughter works, and that you believe she will be earning between $8,000.00 and $10,000.00 in 2017.

10) You testified that your daughter will file her own tax return in 2017, and that you will not be listing her as a dependent on your tax return.

11) You testified that, with the expenses you have for rent, phone, transportation, and food, you cannot afford to pay for a QHP, and would like to be eligible for the Essential Plan.

12) Your application states that you will not be taking any deductions on your 2017 tax return.

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

14) After the hearing, you mailed documentation to NYSOH consisting of the following:

    a. Four paystubs for yourself for the following pay dates and amounts:
        i. June 22, 2017 - $460.00;
        ii. June 29, 2017 - $460.00;
        iii. July 6, 2017 - $460.00;
        iv. July 13, 2017 - $460.00;
        (Document [redacted]).
    b. Four paystubs for your spouse for the following pay dates and amounts:
        i. June 19, 2017 - $605.00;
        ii. June 26, 2017 - $605.00;
        iii. July 3, 2017 - $605.00, year-to-date of $14,963.08;
        iv. July 17, 2017 - $605.00, year-to-date of $16,118.08.
        (Document [redacted]).

    Taken together, these documents are marked and entered into the record as "Appellant's Exhibit One."

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

## Applicable Law and Regulations

Advance Payments of Premium Tax Credit

APTC 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 $20,160.00 for a three-person household, and $24,300.00 for a four-person household (81 Federal Register 4036).

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. For annual household income in the range of at least 250% but less than 300% of the 2016 FPL, the expected contribution 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).

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).

<u>Cost-Sharing Reductions</u>

Cost-sharing reductions (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250% of the FPL for the first day of the open enrollment period of the benefit year for

which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

Essential Plan

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

In an analysis of Essential Plan eligibility, the determination is based on the FPL in effect on the first day of the benefit year for which coverage is requested (45 CFR § 155.300(a)). On the date of your application, that was the 2016 FPL, which is $24,300.00 for a four-person household (81 Fed. Reg. 4036).

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (see 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities, are not an allowable deduction in computing adjusted gross income.

## Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $174.00 per month.

The application that was submitted on January 17, 2017 listed an annual household for your spouse of $26,136.00, and NYSOH relied on that amount. Additionally, you submitted four paystubs to NYSOH in March 2017 that NYSOH utilized to determine that your expected annual income for 2017 was $24,405.94.

During the hearing, you asked that your current expenses, which include rent, phone, transportation, food, and other living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable and phone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, NYSOH correctly determined your household income to be $50,541.94, based on the information you provided,

You are in a four-person household. You indicated in your January 2017 application that you expected to file your 2017 income taxes as married filing jointly and to claim two dependents on that tax return.

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

An annual income of $50,541.94 is 207.99% of the 2016 FPL for a four-person household. At 207.99% of the FPL, the expected contribution to the cost of the health insurance premium is 6.71% of income, or $282.61 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 ($282.61 per month), which equals $173.85 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $174.00 per month in APTC, based on the information in your January 2017 application, and the income documentation you provided in March 2017.

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 $50,541.94 is 207.99% of the applicable FPL, NYSOH correctly found

you to be eligible for cost sharing reductions, based on the information in your application.

The third issue under review is whether NYSOH properly determined that you were not eligible for the Essential Plan as of April 12, 2017.

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 $24,300.00 for a four-person household. Since an annual household income of $50,541.94 is 207.99% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan, based on the information and documentation you provided.

Therefore, since the April 12, 2017 eligibility determination properly found you eligible for up to $174.00 in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, based on the information available to NYSOH at the time, it is AFFIRMED.

However, during the hearing, you testified that you now expect your daughter to file her own tax return, and that you will not be claiming her as a dependent, but will only claim your son. Additionally, after the hearing, you provided paystubs for yourself and your spouse. Based on the paystubs, your spouse's average weekly earnings are $594.00, for an annual income of $30,888.00. Your paystubs show that your average weekly earnings are $460.00, for an annual income of $23,920.00. Therefore, your expected annual household income for 2017 is $54,808.00.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, based on a three-person household with an expected annual income of $54,808.00, residing in [redacted].

## Decision

The April 12, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, based on a three-person household with an expected annual income of $54,808.00, residing in [redacted].

## Effective Date of this Decision: August 9, 2017

## How this Decision Affects Your Eligibility

You were eligible for up to $174.00 per month in APTC, based on the information available when NYSOH ran your eligibility on April 11, 2017.

You were eligible for cost-sharing reductions, based on the information available when NYSOH ran your eligibility on April 11, 2017.
You are not eligible for the Essential Plan.

Your case is being returned to NYSOH to redetermine your eligibility, based on a three-person household with an expected annual income of $54,808.00, residing in [redacted]

NYSOH will notify you of your updated eligibility for financial assistance.

## 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

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: 1-877-369-0129

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 April 12, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance, based on a three-person household with an expected annual income of $54,808.00, residing in [redacted].

You were eligible for up to $174.00 per month in APTC, based on the information available when NYSOH ran your eligibility on April 11, 2017.

You were eligible for cost-sharing reductions, based on the information available when NYSOH ran your eligibility on April 11, 2017.

You are not eligible for the Essential Plan.

NYSOH will notify you of your updated eligibility for financial assistance.

## Legal Authority

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

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

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

[redacted]

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

## Getting Help in a Language Other than English

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

**Español (Spanish)**

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

**中文 (Traditional Chinese)**

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

**Kreyòl Ayisyen (Haitian Creole)**

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

**中文 (Simplified Chinese)**

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

**Italiano (Italian)**

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

**한국어 (Korean)**

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

**Русский (Russian)**

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

**العربية (Arabic)**

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

**□□□□□ (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 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)**

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).

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).