



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

Notice of Decision

Decision Date: October 13, 2017

NY State of Health Account ID [REDACTED]
Appeal Identification Number: AP000000019168

[REDACTED]

Dear [REDACTED],

On September 13, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's May 13, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: October 13, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019168



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 \$172.00 per month in advance payments of the premium tax credit (APTC), effective June 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 February 14, 2017, NYSOH issued an eligibility determination notice, based on your February 13, 2017 updated application, stating you were eligible to enroll in the Essential Plan with a \$20.00 monthly premium for a limited time, effective March 1, 2017. The notice directed you to submit proof of your income by May 14, 2017 to confirm your eligibility or you might lose your insurance or receive less help paying for your coverage.

On February 19, 2017, NYSOH issued a plan enrollment notice confirming your enrollment in the Essential Plan 1 with a \$20.00 monthly premium and a start date of March 1, 2017.

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On May 12, 2017, NYSOH verified the income documentation you submitted and your application was updated to include an increase in your household income from \$25,310.20 to \$35,997.28.

On May 13, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to \$172.00 per month in APTC and eligible for cost-sharing reductions, if you enrolled in a silver level qualified health plan, effective June 1, 2017. The notice also stated that you were not eligible for Essential Plan because your household income of \$35,997.28 was over the allowable income limit for that program.

Also on May 13, 2017, NYSOH issued a cancellation notice stating your Essential Plan enrollment was terminated, effective May 31, 2017, because you were no longer eligible to enroll in the plan.

On May 22, 2017, you spoke to NYSOH's Account Review Unit and appealed the termination of your Essential Plan because you believe that your adjusted gross income as reported on 2015 income tax return is not an accurate reflection of your household income for 2017.

On May 26, 2017, NYSOH issued an eligibility determination notice stating you had been granted aid to continue pending the decision on your appeal. You were re-enrolled in the Essential Plan 1, effective June 1, 2017.

On September 13, 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 September 28, 2017, to allow you to submit supporting documents.

On September 28, 2017, the Appeals Unit received eight pages of documents that include a one page statement signed by you and gross income and expense statements. These documents were made part of the record collectively as Appellant's Exhibit # 1. The record is now closed.

Findings of Fact

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

- 1) You are applying for health insurance for yourself.
- 2) You testified that you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim no dependents on that tax return.
- 3) You testified that you have not filed your 2016 income taxes and you are presently on extension to file a tax return for that period.

- 4) On your February 13, 2017 application for financial assistance, you attested to a household income of \$25,310.20 consisting of various income you and your spouse receive. Based on this attested income amount, you were determined conditionally eligible to enroll in the Essential Plan pending receipt of documentation to confirm your household income.
- 5) According to your NYSOH account, on May 12, 2017, the 2015 income tax return you submitted was verified as proof of household income and your application was updated. Your household income was increased from \$25,310.20 to \$35,997.28 and an updated application was submitted on your behalf.
- 6) The application that was submitted on your behalf on May 12, 2017 listed annual household income of \$35,997.28 consisting of \$13,923.00 you earn from your self-employment and a total of \$22,074.28 in income for your spouse. Your spouse's income consisted of \$1,136.28 she earns from a business, \$15,120.00 in social security benefits and \$5,818.00 in pensions. You testified that the income listed for your spouse was correct, but that the \$13,923.00 NYSOH listed as your income was not correct.
- 7) You testified that your income listed in the May 12, 2017 system updated application is too high as it is based on the 2015 income tax return. You testified that your 2017 income will not be as high as it was in 2015 because you had a better year in earnings in 2015.
- 8) You testified that you are self-employed in a [REDACTED]. You testified that your [REDACTED] in 2017 is significantly lower than it was in 2015.
- 9) You testified that in 2017 you do not have any income from the [REDACTED], which income you had in 2015.
- 10) You testified that you only earned \$331.51 from the [REDACTED] in 2017, which is less than in 2015.
- 11) According to documents you submitted, your earnings from your business through July 2017 were \$9,994.38 and you testified that as of September that amount is still accurate (see Document [REDACTED]).
- 12) According to your May 12, 2017 updated application, you will be taking \$7,645.00 deductions on your 2017 tax return.
- 13) Your application states that you live in [REDACTED], New York.

- 14) You testified that you want to be found eligible for the Essential Plan because health insurance is not affordable even with APTC.

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 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.

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 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 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

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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)).

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 an APTC of up to \$172.00 per month.

In the February 13, 2017 updated application for financial assistance, you listed your household income at \$25,310.20. At that time, you were determined conditionally eligible for the Essential Plan with a \$20.00 monthly premium pending receipt of proof of household income.

On May 12, 2017, the 2015 income tax return you submitted was verified as proof of household income and your application was updated to include an increase in your household income from \$25,310.20 to \$35,997.28, and the eligibility determination relied upon this updated income.

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

You reside in [REDACTED], where the second lowest cost silver plan available for an individual through NYSOH costs \$390.79 per month.

An annual income of \$35,997.28 is 224.70% of the 2016 FPL for a two-person household. At 224.70% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 7.31% of income, or \$219.25 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 (\$390.79 per month) minus your expected contribution (\$219.25 per month), which equals \$171.54 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined that you were eligible for up to \$172.00 per month in APTC based on a household income of \$35,997.28.

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 \$35,997.28 is 224.70% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you were ineligible for the Essential Plan, effective June 1, 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 \$16,020.00 for a two-person household. Since an annual household income of \$35,997.28 is 224.70% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the May 13, 2017, eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$172.00 per

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month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

However, you testified that your 2015 income is not reflective of your 2017 income and you requested that your eligibility be redetermined based on the other income documentation you have submitted.

It is noted that you testified that you have not yet filed your 2016 joint income tax return and are on extension to do so. Therefore, that document is not available for use in determining your eligibility.

You testified that there are no changes in your spouse's income for 2017 and that listed income of \$22,074.28 on the May 12, 2017 updated application.

You further testified that your income for 2017 is less than what you earned from your self-employment in 2015. You testified that you do not have income from the [REDACTED] for 2017 and that you only earned \$331.51 from the [REDACTED] in 2017 before that contract ended. You submitted an income and expense spreadsheet showing you had earned \$9,994.38 up to the end of July 2017 and you testified that was still a good income figure as of September 2017. Based on income of \$9,994.38 through September 2017 this would average to \$1,110.48 in income per month. On an annual basis, this would be \$13,325.84 plus \$331.51 from the [REDACTED] for a total income for 2017 of approximately \$13,657.00.

Based on an estimated income of \$13,657.00 and your spouse's income of \$22,074.00, your projected household income for 2017 would be \$35,731.00. As noted above, NYSOH used the household income amount of \$35,997.28 in determining your eligibility for financial assistance. The difference in these two amounts (\$35,997.28 - \$35,731.00) is \$266.28. This amount of change in your household income is minor and would not make a difference in the calculation of your eligibility for financial assistance or in the amount of APTC you would be entitled to on a monthly basis.

You testified that you cannot afford health insurance even with APTC. 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 May 13, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 13, 2017

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How this Decision Affects Your Eligibility

You remain eligible for up to \$172.00 per month in APTC in 2017.

You are eligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

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.

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If You Have Questions about this Decision (Customer Service Resources):

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NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The May 13, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for up to \$172.00 per month in APTC in 2017.

You are eligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

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 مجاناً.

বাংলা (Bengali)

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

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Français (French)

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

हिंदी (Hindi)

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

日本語 (Japanese)

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

नेपाली (Nepali)

यो एउटा महत्वपूर्ण कागजात हो। यसलाई बुझ्न तपाईंलाई मद्दत चाहिन्छ भने, कृपया 1-855-355-5777 मा फोन गर्नुहोस्। हामीले तपाईंले बोल्ने भाषामा तपाईंलाई निःशुल्क दोभाषे उपलब्ध गराउन सक्छौं।

Polski (Polish)

To jest ważny dokument. W przypadku konieczności skorzystania z pomocy w celu zrozumienia jego treści należy zadzwonić pod numer 1-855-355-5777. Istnieje możliwość uzyskania bezpłatnej usługi tłumacza języka, którym się posługujesz.

Twi (Twi)

Krataa yi ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi 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.

אידיש (Yiddish)

דאס איז א וויכטיגער דאקומענט. אויב איר דארפט הילף עס צו פארשטיין, ביטע רופט 1-855-355-5777. מיר קענען איר געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.

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