



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

## Notice of Decision

Decision Date: October 3, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000019245

[REDACTED]

Dear [REDACTED]

On September 8, 2017, you appeared by telephone at an adjourned hearing on your appeal of NY State of Health's May 18, 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 3, 2017

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000019245



## Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Did NY State of Health properly determine you and your spouse were eligible to receive \$582.00 per month in advance payments of the premium tax credit, effective July 1, 2017?

Did NY State of Health properly determine you and your spouse were eligible for cost-sharing reductions?

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

Did NY State of Health properly determine your children were eligible for Child Health Plus with a \$9.00 monthly premium each, effective July 1, 2017?

## Procedural History

NYSOH received an updated application for financial assistance submitted on behalf of you, your spouse, and your children on May 17, 2017.

On May 18, 2017, NYSOH issued a notice of eligibility determination stating you and your spouse were eligible to receive up to \$582.00 per month in advance payments of the premium tax credit (APTC), effective July 1, 2017. The notice also indicated you and your spouse were eligible for cost-sharing reductions if you enrolled in a silver level qualified health plan. The notice indicated that you

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and your spouse were not eligible for Medicaid or the Essential Plan, because your household income was over the allowable limit for those programs. The notice further stated that your children were eligible for Child Health Plus with a \$9.00 monthly premium each, effective July 1, 2017.

On May 24, 2017, you spoke to NYSOH's Accounts Review Unit and appealed the eligibility determination insofar as you and your spouse were not eligible for the Essential Plan.

On June 2, 2017, NYSOH issued an eligibility determination notice indicating you and your spouse had been granted "Aid to Continue" in your Essential Plan pending the decision on your appeal. You and your spouse were reenrolled into an Essential Plan, effective June ,1 2017.

On August 29, 2017, you were scheduled to have a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. That day a Hearing Officer called you but you were unable to go forward with your scheduled hearing. You requested an adjournment and it was granted.

On September 8, 2017, you had an adjourned telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. While under oath, you waived your right to written notice of the hearing. The record was developed during the hearing and closed thereafter.

## **Findings of Fact**

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

- 1) You are seeking insurance for you, your spouse, and your children.
- 2) You testified you are seeking review of the eligibility of you and your spouse for the Essential Plan. You testified you are also seeking review of your children's eligibility for Child Health Plus with no premium. The issue under appeal was amended accordingly. You testified you are not seeking review of your family's eligibility for Medicaid.
- 3) An updated application was submitted on behalf of you, your spouse, and your children on May 17, 2017. That application listed your annual household income as \$54,000.00, consisting solely of income you earned through your employment. You testified that amount was accurate at the time of the application.
- 4) You testified you received a raise in July 2017 and you are now earning \$59,000.00 annually.

- 5) Your application indicates you will file your 2017 tax return with a tax filing status of married filing jointly and you will claim two dependents on that tax return. You testified that information was accurate.
- 6) You testified, and your application indicates, you will not take any deductions on your 2017 tax return.
- 7) You testified, and your application indicates, you reside in Nassau County.
- 8) You testified that you are the only one working in your household and you have various household expenses you must pay that should be considered when determining your eligibility for financial assistance.
- 9) You and your spouse were granted aid to continue and reenrolled in your Essential Plan pending the outcome of the decision in your appeal.

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

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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 \$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 (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%

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of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

### Essential Plan

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

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

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)).

### Child Health Plus

Child Health Plus (CHP) is a sliding-scale-premium program for children who are in a household that is over income for regular Medicaid (see New York Public Health Law (NY PHL) § 2510 et seq. and 42 USC § 1397aa). Eligibility rules are set out in NY PHL § 2511(2), as well as in the NYS Department of Health 2008-2012 Contract and Plan Manual.

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)). To be eligible to enroll in CHP with subsidy payments, a child must not be “eligible for medical assistance”; that is, must not be eligible for Medicaid (NY PHL § 2511(2)(b)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child’s family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children

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whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from \$9.00 per month to \$60.00 per month (NY PHL § 2510(9)(d)).

The CHP premium is \$9.00 per month for a child whose family household income is between 160% and 222% of the FPL, but no more than \$27.00 per month per family (NY PHL § 2510(9)(d)(ii)).

In an analysis of Child Health Plus 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 was \$24,600.00 for a four-person household (80 Federal Register 3236, 3237).

## **Legal Analysis**

The first issue is whether NYSOH properly determined you and your spouse were eligible for an APTC of \$582.00 per month, effective July 1, 2017.

The application submitted on May 17, 2017 listed an annual household income of \$54,000.00. You testified that amount was correct at the time of the application and the eligibility determination relied upon that information.

Although you testified the income amount listed in your application was accurate, you further testified that you have various household expenses you must pay that should be considered when determining your eligibility for financial assistance. However, 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 \$54,000.00.

You are in a four-person household. You testified, and your application indicates, you expect to file your 2017 income taxes with a tax filing status of married filing jointly and will claim two dependents on that tax return.

You reside in Nassau County, where the second lowest cost silver plan available for a couple through NYSOH costs \$907.13 per month.

An annual income of \$54,000.00 is 222.22% of the 2016 FPL for a four-person household. At 222.22% of the FPL, the expected contribution to the cost of the health insurance premium is 7.22% of income, or \$324.90 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 a couple in your county (\$907.13 per month) minus your expected contribution (\$324.90 per

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month), which equals \$582.23 per month. Rounding to the nearest dollar, NYSOH correctly determined you and your spouse eligible to receive up to \$582.00 per month in APTC, effective July 1, 2017.

The second issue is whether you and your spouse were properly found eligible for cost-sharing reductions.

Cost-sharing reductions are available to applications with a household income no greater than 250% of the FPL. Since a household income of \$54,000.00 is 222.22% of the applicable FPL, NYSOH correctly found you and your spouse eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined you and your spouse 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 \$24,300.00 for a four-person household. Since an annual household income of \$54,000.00 is 222.22% of the applicable FPL, NYSOH properly found you and your spouse ineligible for the Essential Plan.

The fourth issue under review is whether NYSOH properly determined your children were eligible to enroll in Child Health Plus with a \$9.00 per monthly premium each, effective July 1, 2017.

As discussed above, you attested in your May 17, 2017 updated application that your annual expected household income was \$54,000.00 and that your children were in a four-person household.

A child is eligible to enroll in Child Health Plus if they meet the non-financial requirements, are not eligible for Medicaid, and have a household income below 400% of the FPL. Households with an income between 160% and 222% of the FPL are responsible for a \$9.00 per month Child Health Plus premium payment per child, not to exceed \$27.00 per month per family. On the date of your application, the relevant FPL was \$24,600.00 for a four-person household. Since \$54,000.00 is 219.51% of the 2017 FPL, NYSOH properly found your children to be eligible for Child Health Plus with a \$9.00 per month premium payment each.

Since the May 18, 2017 eligibility determination properly stated that, based on the information you provided, you and your spouse were eligible for up to \$582.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan, and your children were eligible for Child Health Plus with a \$9.00 per month premium payment each, it is correct and is AFFIRMED.

However, it is noted that you testified your income has increased since your most recent application was filed. You stated that in July your annual earnings increased to \$59,000.00 per year. Earning \$54,000.00 for the first half of the year and \$59,000.00 the second half of the year equates to expected annual earnings for 2017 of \$56,500.00.

Therefore, your case is returned to NYSOH to redetermine your eligibility for APTC from this point forward, based on expected annual earnings for 2017 of \$56,500.00.

## **Decision**

The May 18, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** October 3, 2017

## **How this Decision Affects Your Eligibility**

You and your spouse remain eligible for up to \$582.00 in APTC.

You and your spouse remain eligible for cost-sharing reductions.

You and your spouse are ineligible for the Essential Plan.

Your children are eligible for Child Health Plus with a \$9.00 per month premium payment each.

Your case is returned to NYSOH to redetermine your eligibility for APTC from this point forward, based on expected annual earnings for 2017 of \$56,500.00.

## **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.

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Additionally, Appeals Unit decisions on issues involving eligibility for qualified health plans, advance premium tax credits, and cost-sharing reductions may be appealed to the Federal Marketplace. This must be done within 30 days of the Decision Date, which appears on the first page of this Decision (45 CFR § 155.520(c)).

If you have questions about appealing to the Federal Marketplace, you can contact them in any of the following ways:

- By calling the Customer Service Center at 1-800-318-2596
- By mail at:  
Health Insurance Marketplace  
Attn: Appeals  
465 Industrial Blvd.  
London, KY 40750-0061
- By fax: 1-877-369-0129

If you wish to be represented by an attorney in bringing an outside appeal and do not know how to go about getting one, you may contact legal resources available to you. You may, for example, contact the local County Bar Association, Legal Aid, or Legal Services.

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

You can contact us in any of the following ways:

- By calling the Customer Service Center at 1-855-355-5777
- By mail at:  
NY State of Health Appeals  
P.O. Box 11729  
Albany, NY 12211
- By fax: 1-855-900-5557

### **Summary**

The May 18, 2017 eligibility determination notice is **AFFIRMED**.

You and your spouse remain eligible for up to \$582.00 in APTC.

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You and your spouse remain eligible for cost-sharing reductions.

You and your spouse are ineligible for the Essential Plan.

Your children are eligible for Child Health Plus with a \$9.00 per month premium payment each.

Your case is returned to NYSOH to redetermine your eligibility for APTC from this point forward, based on expected annual earnings for 2017 of \$56,500.00.

### **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 مجاناً.

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## **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।

## **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&ctumi 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 אייך געבן א דאלמעטשער פריי פון אפצאל אין די שפראך וואס איר רעדט.