



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

Notice of Decision

Decision Date: October 04, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019707

[REDACTED]

Dear [REDACTED],

On September 14, 2017 you appeared by telephone at a hearing on your appeal of NY State of Health's June 6, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: October 04, 2017

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000019707



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 up to \$290.00 per month in advance payments of the premium tax credit, effective July 1, 2017?

Procedural History

On May 25, 2017, you submitted an application for financial assistance.

On May 26, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating that you were eligible to enroll in the Essential Plan for a limited time, effective July 1, 2017. This notice directed you to submit documentation of your household income by August 23, 2017 in order to confirm your eligibility for financial assistance.

On June 3, 2017, income documentation was uploaded to your NYSOH account.

On June 5, 2017, NYSOH verified the income documentation you submitted, recalculated your income based on the documentation you submitted, updated the income information in your application based on this calculation, and submitted an application on your behalf.

On June 6, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to \$290.00 per month in advance payments of the premium tax credit (APTC), effective July 1, 2017. That notice also stated that

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you were not eligible for cost-sharing reductions or the Essential Plan because your income was over the allowable income limits for those programs.

On June 12, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were found ineligible for the Essential Plan.

On June 15, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible for the Essential Plan for a limited time, effective June 1, 2017. This was because you had been granted Aid to Continue until a decision was made on your appeal.

On September 14, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and left open for fourteen days to allow you the opportunity to submit additional documentation.

On September 27, 2017, the Appeals Unit received via fax copies of your 2017 school tax bill, your 2016 property tax bill, and three paystubs. These documents were collectively marked as Appellant's Exhibit #1 and incorporated into the record. 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 single. You will claim no dependents on that tax return.
- 2) You are seeking insurance for yourself.
- 3) You testified that you will not be taking any deductions on your 2017 tax return.
- 4) Your application states, and you confirmed, that you live in Broome County.
- 5) The application that was submitted on May 25, 2017 listed annual household income of \$19,638.01, consisting of \$10,963.49 you earn from your employment at [REDACTED], \$2,695.00 you earn from your employment at [REDACTED] and \$6,941.00 you receive in Social Security Benefits, less \$961.00 in 401(k) deductions.
- 6) On February 7, 2017 income documentation was uploaded to your NYSOH account consisting of two paystubs from [REDACTED], a Social Security Award letter, and a letter from the New York State retirement

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system. The first paystub from [REDACTED] is for pay date December 29, 2016 for a gross pay amount of \$529.09, the second is for pay date January 12, 2017 for a gross pay amount of \$314.29. The Social Security Award letter is dated January 14, 2017 and indicates that beginning on or around February 8, 2017 you would begin receiving \$631.00 per month. The letter from the New York State retirement system is dated January 18, 2017 and indicates that beginning in February 2017 you will begin receiving approximately \$244.00 per month.

- 7) On June 3, 2017 income documentation was uploaded to your NYSOH account consisting of two paystubs from [REDACTED] two paystubs from [REDACTED], a print-out from the Social Security Administration, and a letter from the New York State retirement system. The first paystub from [REDACTED] is for pay date May 18, 2017 for a gross pay amount of \$537.33, the second is for pay date June 1, 2017 for a gross pay amount of \$537.72. The first paystub from [REDACTED] is for pay date May 11, 2017 for a gross pay amount of \$161.33, the second paystub is for pay date May 25, 2017 for a gross pay amount of \$124.10. The print-out from the Social Security Administration shows that you are receiving \$631.00 per month. The letter from the New York State retirement system is dated January 27, 2017 and indicates that you will receiving \$234.14 per month in pension benefits.
- 8) On June 5, 2017, NYSOH recalculated your annual expected income to be \$31,237.76 consisting of \$13,975.65 from [REDACTED] t, \$3,710.59 from [REDACTED], \$6,941.00 in Social Security Benefits, and \$7,572.00 in pension benefits, less \$961.00 in 401(k) deductions.
- 9) You testified that you are not sure what your expected annual income for 2017 is. You testified that your current income consists of wages from [REDACTED], Social Security Benefits, and your pension.
- 10) You testified that your pay at [REDACTED] varies, but that you are paid an hourly rate of \$13.20 and work anywhere from eight to twenty hours per week and are paid on a biweekly basis. You testified that you receive \$631.00 per month in Social Security Benefits, which you began receiving in February 2017. You testified that you stopped working at [REDACTED] the week prior to the September 14, 2017 hearing. You testified that you also receive a pension benefit of approximately \$231.00 per month.
- 11) On September 27, 2017 you submitted additional documentation consisting of your school tax bill for 2017, your property tax bill for 2017, two paystubs from [REDACTED], and your final paystub from [REDACTED]. The 2017 school tax bill indicates that your total tax due was \$812.86. The property tax bill for 2016 indicates that your total tax due was \$1,761.38. The first paystub from [REDACTED] is for pay date September 7, 2017 for a

gross pay amount of \$539.29, the second is for pay date September 21, 2017 for a gross pay amount of \$528.88 and a year to date gross amount of \$8,579.34. Your final paystub from [REDACTED] is for check dated September 28, 2017 for a gross amount of \$161.33.

- 12) You testified that you have bills including a car payment of \$263.00 per month, property taxes, school taxes, car insurance of \$105.00 per month, utilities of \$105.00 per month, and water and garbage of \$98.00 and \$78.00 respectively every three months, that you would like considered when determining your eligibility for financial assistance.

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 \$11,880.00 for a one-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).

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).

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

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).

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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 \$11,880.00 for a one-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)).

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 tax 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 issue is whether NYSOH properly determined that you were eligible for an APTC of up to \$290.00 per month.

The application that was submitted on May 25, 2017 listed annual household income of \$19,638.01. NYSOH requested income documentation in order to confirm your eligibility for financial assistance.

On June 3, 2017 income documentation was uploaded to your NYSOH account consisting of two paystubs from [REDACTED], two paystubs from [REDACTED], a print-out from the Social Security Administration, and a letter from the New York State retirement system. The first paystub from [REDACTED] is for pay date May 18, 2017 for a gross pay amount of \$537.33, the second is for pay date June 1, 2017 for a gross pay amount of \$537.72. The first paystub from [REDACTED] is for pay date May 11, 2017 for a gross pay amount of \$161.33, the second paystub is for pay date May 25, 2017 for a gross pay amount of \$124.10. The print-out from the Social Security Administration shows that you are receiving \$631.00 per month. The letter from the New York State retirement system is dated January 27, 2017 and indicates that you will be receiving \$234.14 per month in pension benefits.

Based on this income documentation, NYSOH recalculated your annual expected income to be \$31,237.76 consisting of \$13,975.65 from [REDACTED] (\$537.33 plus \$537.72 for a gross of \$1,075.05 divided by 4 weeks for a weekly average of \$268.76 multiplied by 52 weeks), \$3,710.59 from [REDACTED] (161.33 plus \$124.10 for a gross of \$285.43 divided by 4 weeks for a weekly average of \$71.36 multiplied by 52 weeks), \$6,941.00 in Social Security Benefits (\$631.00 for 11 months), and \$7,572.00 in pension benefits, less \$961.00 in 401(k) deductions.

However, the pension benefits calculated by NYSOH were incorrect. You submitted documentation showing that your monthly pension benefit is \$234.14 per month, which yields a gross annual amount of \$2,809.68 rather than the \$7,572.00 calculated by NYSOH.

During the hearing, you asked that your current expenses, which include car payment of \$263.00 per month, property taxes of \$1,761.38, school taxes of 812.86, car insurance of \$105.00 per month, utilities of \$105.00 per month, and water and garbage of \$98 and \$78 respectively every three months, as well as other living expenses, be considered when calculating your annual household income.

Since the Internal Revenue Service rules do not allow living expenses such as car payments, car insurance, or utilities to be deducted from the calculation of your adjusted gross income, nor do they allow taxes such as school taxes or property taxes to be deducted from the calculation of your adjusted gross income they cannot be deducted when NYSOH computes your modified adjusted gross income for APTC purposes.

Therefore, based on the income documentation you had submitted at the time of the June 5, 2017 eligibility redetermination, NYSOH should have calculated your annual expected income to be \$26,475.92.

Therefore, the June 6, 2017 eligibility determination stating that you were eligible for up to \$290.00 per month in APTC based on an annual expected income of \$31,237.76 is RESCINDED.

You testified that you expect to file your 2017 tax return as single and will claim no dependents on that tax return. Therefore, you are in a one-person household.

You reside in Broome County.

During the hearing, you testified that your household income had changed as you were no longer working for one of your employers. You produced current income documentation which indicates that your annual expected income is now \$24,377.00.

Therefore, your case is RETURNED to redetermine your eligibility for financial assistance based on a household of one person, residing in Broome County, with an annual expected income of \$24,377.00.

Decision

The June 6, 2017 eligibility determination is RESCINDED.

Your case is RETURNED to redetermine your eligibility for financial assistance based on a household of one person, residing in Broome County, with an annual expected income of \$24,377.00.

Effective Date of this Decision: October 04, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

Your case is being sent back to NYSOH to redetermine your eligibility based on the income documentation you provided following your hearing.

If You Disagree with this Decision (Appeal Rights)

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).

This Decision is final unless you submit an appeal request to the Federal Marketplace or bring a lawsuit under New York Civil Practice Law and Rules, Article 78.

You may bring a lawsuit on any Appeals Unit decision in New York State court in accordance with Article 78 of the New York Civil Practice Law and Rules. This must be done within four months of the Decision Date, which appears on the first page of this Decision.

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

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

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

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

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

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

Summary

The June 6, 2017 eligibility determination is RESCINDED.

This is not a final determination of your eligibility.

Your case is RETURNED to redetermine your eligibility for financial assistance based on a household of one, residing in Broome County, with an annual expected income of \$24,377.00.

Your case is also being sent back to NYSOH to redetermine your eligibility as of based on the income documentation you provided following your hearing.

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 okyerε 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.

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