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

Notice of Decision

Decision Date: November 6, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020055

[redacted]

Dear [redacted],

On September 21, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 27, 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: November 6, 2017

NY State of Health Account ID:
Appeal Identification Number: AP000000020055

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health properly determine you were not eligible to receive financial assistance with health insurance, effective August 1, 2017?

Procedural History

On April 6, 2017, NYSOH received an updated application for financial assistance submitted on your behalf.

On April 7, 2017, NY State of Health (NYSOH) issued a notice of eligibility determination stating you were eligible to enroll in the Essential Plan with a $20.00 monthly premium, for a limited time, effective May 1, 2017. The notice directed you to submit proof of your income by July 5, 2017 to confirm the information in your application or you might lose your insurance or receive less help paying for your coverage.

Also on April 7, 2017, NYSOH issued an enrollment notice confirming your enrollment in an Essential Plan, effective May 1, 2017.

On June 26, 2017, NYSOH systematically redetermined your eligibility.

On June 27, 2017, NYSOH issued an eligibility determination notice stating you were eligible to purchase a full cost qualified health plan, effective August 1, 2017. The notice indicated that you were not eligible to receive advance

payments of the premium tax credit (APTC) or to enroll in the Essential Plan, because your household income was over the allowable limit for those programs.

Also on June 27, 2017, NYSOH issued a disenrollment notice stating your enrollment in your Essential Plan would end on July 31, 2017, because you were no longer eligible to enroll in that plan.

Additionally, on June 27, 2017, you spoke to NYSOH's Account Review Unit and appealed the eligibility determination insofar as you were not eligible for the Essential Plan.

On June 29, 2017, NYSOH issued an eligibility determination notice, based on your grant of Aid to Continue, stating you were eligible for the Essential Plan, for a limited time, effective August 1, 2017, until a decision was made on your appeal. You subsequently reenrolled in an Essential Plan, effective August 1, 2017.

On September 21, 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 allow you to submit supporting documents. Also on September 21, 2017, you uploaded the requested documentation to your NYSOH account and the same was incorporated into the record as Appellant's Exhibit #1.

Findings of Fact

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

1) You updated your application April 6, 2017. That application listed your annual income as $23,348.00, consisting of $349.00 you attested to earning weekly at your first job and $100.00 you attested to earning weekly at your second job.

2) That application indicated you would file your 2017 tax return with a tax filing status of single and you would claim no dependents. You testified this information was accurate.

3) Your application indicated you reside in Kings County and that you will not take any deductions on your 2017 tax return. You testified the information in your application was not accurate, because you will take a student loan interest deduction in 2017. You testified that you were unsure of the amount of the deduction, but that it would be the same as your deduction in 2016. You were directed to submit a copy of your 2016 tax return to establish the amount of the student loan interest deduction you would take in 2017.

4) On September 21, 2017, NYSOH received a copy of your 2016 tax return indicating you took a student loan interest deduction in 2016 in the amount of $134.00.

5) You testified that you might also take a business expense deduction in 2017, but you were unsure of the amount. You were directed to update your NYSOH account with relevant information if you decide to take any additional deductions.

6) According to your account, NYSOH was unable to verify the income information listed in your application and you were determined conditionally eligible for the Essential Plan pending receipt of income documentation to verify your income.

7) On June 26, 2017, the following weekly paystubs were uploaded to your account:

   a. Pay stubs from employer [REDACTED].

      i. May 5, 2017 pay date in the gross amount of $641.38.

      ii. May 12, 2017 pay date in the gross amount of $686.03.

      iii. May 19, 2017 pay date in the gross amount of $750.32.

      iv. May 26, 2017 pay date in the gross amount of $648.01.

   b. Pay stubs from employer [REDACTED]

      i. April 14, 2017 pay date in the gross amount of $191.50.

      ii. April 21, 2017 pay date in the gross amount of $294.53.

      iii. April 28, 2017 Pay date in the gross amount of $238.27.

      iv. May 5, 2017 pay date in the gross amount of $186.80

8) According to your account, on June 26, 2017, NYSOH verified your income documentation and increased your annual household income amount from [REDACTED] to $36,850.84, purportedly based on the average gross weekly income in the paystubs submitted. NYSOH also recalculated your annual income from [REDACTED] as $11,844.63 based on the average gross weekly income in the paystubs submitted. NYSOH recalculated your annual household income to be $48,695.14 and determined you over income to receive financial assistance with health insurance.

9) You testified that the recalculated annual income amount may be a little high, because your pay varies with the number of hours you work. You further testified that the recalculated income amount was in the "ballpark."

10) You testified you are seeking eligibility to enroll in the Essential Plan.

11) You were granted Aid to Continue and reenrolled in an Essential Plan pending the outcome of your appeal.

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 300% but less than 400% of the 2016 FPL, the expected contribution is 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

People who use the APTC to help pay health insurance premiums must file a federal tax return and reconcile their expected income (stated on NYSOH application) with their actual income (stated on their federal income tax return). Those who take less tax credit in advance than they claim on the tax return may get the rest of it as an income tax refund or have their tax bill reduced. Those who take more tax credit in advance than they can claim on their tax return will owe the difference as additional income taxes (26 CFR § 1.36B-4).

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 $11,880.00 for a one-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)).

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 issue is whether NYSOH properly determined you were not eligible to receive financial assistance with health insurance.

The updated application submitted on April 6, 2017 listed an annual household income of $23,348.00 consisting of $349.00 you attested to earning weekly at your one job and $100.00 you attested to earning weekly at your second job. However, according to your account, NYSOH was unable to verify that information and income documentation was requested.

On June 26, 2017, NYSOH received four weekly paystubs from each of your two employers. NYSOH recalculated your annual income from each job purportedly based on the average of the gross weekly income in the paystubs submitted. NYSOH recalculated your annual income from your job with [redacted] as $11,844.63. It is concluded that this calculation was accurate based on your paystubs. However, NYSOH recalculated your annual income from your job at [redacted] as $36,850.84. It is concluded that this was a miscalculation of your average weekly gross income from the paystubs submitted. Based on the paystubs submitted, your average weekly gross income from [redacted] is $35,434.62.

Furthermore, you testified, and submitted corroborating evidence, that you will take a student loan interest deduction on your 2017 tax return in the amount of $134.00. Thus, you are entitled to a reduction in the income amount used to determined your eligibility for financial assistance through NYSOH in the amount of that deduction.

Thus, the evidence establishes that your gross annual income for 2017, based on the competent evidence of record, is $47,145.25 rather than the amount of $48,695.14 used by NYSOH to determine you were not eligible to receive financial assistance with health insurance.

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).

Accordingly, the June 27, 2017 eligibility determination stating you were not eligible to receive financial assistance with health insurance was based on inaccurate information and thus, must be RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a household size of one and an annual expected household income amount for 2017 of $47,145.25.

It is noted that you testified that your living expenses make paying for health insurance impossible and, therefore, such expenses should be considered in the calculation of your eligibility. 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 eligibility purposes. Therefore, the competent evidence of record establishes that your modified adjusted gross income, for the purposes of determining your eligibility for financial assistance with health insurance through NYSOH, is $47,145.25.

Decision

The June 27, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a household size of one and an annual household income amount of $47,145.25.

Effective Date of this Decision: November 6, 2017

How this Decision Affects Your Eligibility

This is not a final determination of your eligibility.

You will receive an updated eligibility determination from NYSOH.

If You Disagree with this Decision (Appeal Rights)

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

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

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

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

- 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 June 27, 2017 eligibility determination notice is RESCINDED.

Your case is RETURNED to NYSOH to redetermine your eligibility for financial assistance based on a household size of one and an annual household income amount of $47,145.25.

This is not a final determination of your eligibility.

You will receive an updated eligibility determination from NYSOH.

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:

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Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

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

Italiano (Italian)

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

한국어 (Korean)

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

Русский (Russian)

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

العربية (Arabic)

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

বাংলা (Bengali)

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 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.

(Urdu)اردو

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)

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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