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

Notice of Decision

Decision Date: October 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020181

[redacted]

Dear [redacted],

On September 24, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 27, 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 12, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020181

[redacted]

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 $324.00 per month in advance payments of the premium tax credit, effective August 1, 2017?
>
> Did NY State of Health properly determine that you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you were ineligible for the Essential Plan?

Procedural History

On April 24, 2017, you submitted an application for financial assistance.

On April 25, 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 June 1, 2017. This notice directed you to submit proof of your income by July 23, 2017 in order to confirm your eligibility for financial assistance.

Also on April 25, 2017, NYSOH issued a notice of enrollment confirmation stating that you were enrolled in an Essential Plan with a plan enrollment start date of June 1, 2017.

On May 16, 2017, you uploaded income documentation to your NYSOH account.

On May 17, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On May 18, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional income documentation was due by July 23, 2017.

On June 5, 2017, you uploaded income documentation to your NYSOH account.

Also on June 5, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On June 6, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional income documentation was due by July 23, 2017.

On June 13, 2017, you uploaded income documentation to your NYSOH account.

Also on June 13, 2017, NYSOH reviewed the income documentation you submitted and determined that this was insufficient to resolve the inconsistency in your account.

On June 14, 2017, NYSOH issued a notice stating that the documentation you submitted did not confirm the information in your application and that additional income documentation was due by July 23, 2017.

On June 26, 2017, you uploaded income documentation to your NYSOH account.

Also on June 26, 2017, NYSOH reviewed the income documentation you submitted, determined that this was sufficient proof of income, recalculated your income based on the documentation you submitted, updated your application to reflect the recalculated income, and submitted an application on your behalf.

On June 27, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive up to $324.00 per month in advance payments of the premium tax credit (APTC) and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective August 1, 2017. That notice also stated that you were not eligible for the Essential Plan because your income was over the allowable income limit for that program.

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

On July 1, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were found ineligible for the Essential plan.

On September 25, 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 income documentation. On October 2, 2017, the Appeals Unit received via fax two paystubs and a list of expenses. 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 and you will claim no dependents on that return.

2) You are seeking insurance for yourself.

3) The application that you submitted on April 24, 2017 listed annual household income of $20,020.00, consisting of wages you earn from your employment.

4) On May 16, 2017, you uploaded three paystubs to your NYSOH account. The pay date and pay period was not viewable on these paystubs.

5) On June 5, 2017, you uploaded four paystubs to your NYSOH account. The first is for pay date April 13, 2017 for a gross pay amount of $520.00; the second is for pay date April 20, 2017 for a gross pay amount of $520.00; the third is for pay date April 27, 2017 for a gross pay amount of $390.00; the fourth is for pay date May 4, 2017 for a gross pay amount of $420.00.

6) On June 13, 2017, you uploaded the same paystubs you uploaded on June 5, 2017.

7) On June 26, 2017, you uploaded four paystubs to your NYSOH account. The first was for pay date May 25, 2017 for a gross pay amount of $520.00; the second was for pay date June 1, 2017 for a gross pay amount of $390.00; the third was for pay date June 8, 2017 for a gross

pay amount of $650.00; the fourth was for pay date June 15, 2017 for a gross pay amount of $300.00 and a gross year to date amount of $12,160.00.

8) On June 26, 2017, NYSOH recalculated your annual income to be $24,180.00 and submitted an application on your behalf based on this recalculated income.

9) You testified that you have worked for the same employer throughout 2017. You explained that you are paid on a weekly basis. You also testified that you are usually paid the same amount, but it does vary based on availability of work. You testified that this is your only source of income.

10) You testified that you pay $100.00 per month in child support, however, the child's mother claims the child as a dependent.

11) You testified that you are not sure what your annual income will be, but your most recent paystub as of the date of the hearing listed gross year to date income of $19,890.00.

12) Your application states that you will not be taking any deductions on your 2017 tax return, and you testified that you believe this is correct.

13) Your application states, and you confirmed, that you live in Bronx County.

14) You testified that you have bills which you would like considered when determining your eligibility for financial assistance. You provided a list of your expenses which include $908.73 per month for rent, $70.00 to $100.00 per month for utilities, $73.40 per month for your cell phone, $194.34 per month for cable, internet, and home phone, $830.00 per 6 months for car insurance, $100.00 per month for child support, $225 to $300.00 per month for groceries, and gas of approximately $50.00 per month.

15) Following the hearing you submitted two paystubs. The first is for check date September 21, 2017 for a gross pay amount of $320.00 and the second is for the period from September 16, 2017 to September 22, 2017 paid on September 28, 2017 for a gross pay amount of $320.00 for a gross year to date amount of $20,210.00.

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).

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).

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.

Generally, payments made for the support of children cannot be deducted by the parent who is making the payments (26 USC § 71(c)(1)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to $324.00 per month.

On June 26, 2017, you uploaded income documentation to your NYSOH. This documentation consisted of four paystubs showing gross earnings of $1,860.00 over the course of four weeks.

Also on June 26, 2017, NYSOH calculated your annual household income to be $24,180.00 ($1,860.00 divided by four weeks for a weekly average of $465.00, multiplied by 52 weeks).

During the hearing, you testified that the amount you provided in your application was correct. However, you asked that your current expenses, which include $908.73 per month for rent, $70.00 to $100.00 per month for utilities, $73.40 per month for your cell phone, $194.34 per month for cable, internet, and home phone, $830.00 per 6 months for car insurance, $100.00 per month for child support, $225 to $300.00 per month for groceries, and gas of approximately $50.00 per month, be considered when determining your eligibility for financial assistance with health insurance.

However, the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable, phone, groceries, and gas to be deducted from the

calculation of your adjusted gross income, therefore they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes.

Additionally, the Internal Revenue Service rules do not allow child support to be deducted by the parent making child support payments.

Therefore, NYSOH correctly determined your household income to be $24,180.00 based on the income documentation you provided.

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

You reside in Bronx County, where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $24,180.00 is 203.54% of the 2016 FPL for a one-person household. At 203.54% of the FPL, the expected contribution to the cost of the health insurance premium is 6.56% of income, or $132.10 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for an individual in your county ($456.46 per month) minus your expected contribution ($132.10 per month), which equals $324.36 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $324.00 per month in APTC.

The second issue 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 $24,180.00 is 203.54% 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.

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 $11,880.00 for a one-person household. Since an annual household income of $24,180.00 is 203.54% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Since the May 27, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to $324.00 per month in

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

Following the hearing you submitted paystubs that show as of September 22, 2017 your gross year to date earnings were $20,210.00. Therefore, based on these paystubs, your annual expected income is $28,403.24 ($20,210.00 divided by 37 weeks worked for a weekly average of $546.22, multiplied by 52 weeks). Therefore, the NYSOH Appeals Unit declines to return your case to NYSOH for any further action.

Decision

The June 27, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: October 12, 2017

How this Decision Affects Your Eligibility

You remain eligible for up to $324.00 in APTC.

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.

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 AFFIRMED.

You remain eligible for up to $324.00 in APTC.

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.

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

A Copy of this Decision Has Been Provided To:

[redacted]

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

Getting Help in a Language Other than English

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

Español (Spanish)

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

中文 (Traditional Chinese)

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

Kreyòl Ayisyen (Haitian Creole)

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

中文 (Simplified Chinese)

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

Italiano (Italian)

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

한국어 (Korean)

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

Русский (Russian)

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

العربية (Arabic)

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

□□□□□ (Bengali)

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

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Français (French)

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

हिंदी (Hindi)

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

日本語 (Japanese)

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

नेपाली (Nepali)

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

Polski (Polish)

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

Twi (Twi)

Krataa yi yɛ tow krataa a ho hia. Sɛ wo hia ɛho nkyerɛkyerɛmu a, yɛ srɛ wo, frɛ 1-855-355-5777. yƐbƐtumi ama wo obi a ɔkyerƐ kasa a woka no ase ama wo kwa a wontua hwee.

اردو (Urdu)

یہ ایک اہم دستاویز ہے۔ اگر آپ کو اسے سمجھنے کے لیے مدد کی ضرورت ہے تو براہ کرم1-855-355-5777 پر کال کریں۔ ہم آپ کو آپ کی مادری زبان میں ایک مفت مترجم فراہم کر سکتے ہیں۔

Tiếng Việt (Vietnamese)

Đây là tài liệu quan trọng. Nếu quý vị cần trợ giúp để hiểu tài liệu này, vui lòng gọi 1-855-355-5777. Chúng tôi có thể cung cấp thông dịch viên miễn phí nói ngôn ngữ của quý vị.

אידיש (Yiddish)

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

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

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