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

Notice of Decision

Decision Date: November 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020619

[redacted]

[redacted]

On October 2, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's July 19, 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 15, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000020619

[redacted]

Issues

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

> Did NY State of Health properly determine you were eligible to receive up to $251.00 per month in advance payments of the premium tax credit, effective September 1, 2017?
>
> Did NY State of Health properly determine you were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine you were not eligible for the Essential Plan?
>
> Did NY State of Health properly determine you were not eligible for Medicaid?

Procedural History

On July 18, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating you were eligible to receive up to $251.00 in advance payments of the premium tax credit (APTC), as well as to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective September 1, 2017.

Also on July 18, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were not eligible for Medicaid.

On July 19, 2017, NYSOH issued a notice of eligibility determination, based on the July 18, 2017 application, stating you were eligible to receive up to $251.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective September 1, 2017. The notice indicated you were not eligible for Medicaid or the Essential Plan, because the household income you provided was over the allowable income limits for those programs.

On October 2, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the hearing.

Findings of Fact

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

1) NYSOH received an updated application for financial assistance submitted on your behalf on July 18, 2017. That application listed your annual expected income as $34,939.84, consisting of $27,102.40 you earned annually at "[redacted]" and $7,837.44 you earned annually on an inconsistent basis from [redacted]

2) You testified that you might earn less in 2017 than the income amount listed in your July 18, 2017 application, but you were unsure.

3) You testified that you were suspended from your job at "[redacted]" for a period in 2017, but you still earned income. You testified that you had not worked at that job since August 2017, but you might start working there again.

4) You testified the annual income amount of $27,102.40 listed for your job at "[redacted]" was accurate and was based on a rate of $13.03 per hour for a 40-hour work week.

5) At the hearing, you identified three additional employers you earned income from in 2017 on a per diem basis. You testified that you earned less than $400.00 from each of those employers.

6) Your application indicated you will file your 2017 tax return with a tax filing status of single. You testified that was accurate.

7) Your application indicated you would claim one dependent on that tax return.

8) You testified you were unsure if you would claim any dependents on your 2017 tax return. You testified that you claimed your little brother as a dependent in 2016 because you paid his school tuition, and you were waiting on permission from your father to confirm whether you would claim him as a dependent for 2017. You listed a different younger brother on your account, and you are not sure if you will be claiming him as a dependent either.

9) Your application indicated you will not take any deductions on your 2017 tax return. You testified that you might take a deduction on that return for tuition and fees, but you were unsure of the amount. You were directed to update your application with accurate information in the event you decided to take any deductions.

10) You testified, and your application indicates, you reside in [redacted]

11) According to your account, you updated your application on October 31, 2017, reducing your attested annual income to the $27,102.40 you will earn annually at [redacted]." That application indicates you have no other income for 2017.

12) You were determined conditionally eligible for the Essential Plan with a $20.00 monthly premium, effective December 1, 2017, based on your October 31, 2017 application. You were directed to submit proof of your income by January 29, 2017 to confirm your eligibility.

13) As of the date of this decision, there is no record of any income documentation received by NYSOH.

14) You testified that you have bills including rent, that you think should be considered when determining your eligibility for health insurance. You further testified that your net income should be used to determined your eligibility, because you do not actually receive the gross income amount.

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 $16,020.00 for a two-person household and $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 $16,020.00 for a two-person household and $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 www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

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)).

Medicaid

Medicaid can be provided through NYSOH to adults who: (1) are age 19 or older and under age 65, (2) are not pregnant, (3) are not entitled to or enrolled for Medicare benefits under part A or B of title XVIII of the Act, (4) are not otherwise eligible for and enrolled for mandatory coverage under a State's Medicaid State plan in accordance with subpart B of this part, and (5) have a household modified adjusted gross income (MAGI) that is at or below 138% of the FPL for the applicable family size (42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)), NY Social Services Law § 366(1)(b)).
In an analysis of Medicaid 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 is $16,240.00 for a two-person household and $12,060.00 for a one-person household (82 Fed. Reg. 8831).

Financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size (42 CFR § 435.603(h)(1); State Plan Amendment (SPA) 13-0055-MM3, as approved March 19, 2014).

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 first issue is whether NYSOH properly determined you were eligible for an APTC of up to $251.00 per month, effective September 1, 2017.

The application submitted on July 18, 2017 listed an annual income of $34,939.84 consisting of $27,102.40 you earned annually at [redacted]" and $7,837.44 you earned annually on an inconsistent basis from [redacted]." You testified that the annual income amount listed for [redacted]" was accurate, but you were suspended for a period of time from your second job, although you continued to receive paychecks, and your total income for 2017 might be less than the amount listed in your application.

It is noted that the eligibility determination under review was based upon the income information you provided in your July 18, 2017 application. Because you have yet to provide any documentation of your income, it is concluded that NYSOH properly relied upon your own attestation of your expected income for 2017.

It is noted that during the hearing, you contended that your net income should be used to determined your eligibility for financial assistance, rather than your gross, because you do not actually receive the gross income amount. NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code. 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.

Additionally, 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. Because 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, NYSOH correctly determined your eligibility based on the annual gross income amount attested to in your application of $34,939.84.

Your application indicated that you will file your 2017 tax return with a tax filing status of single and you will claim one dependent on that tax return. Although you testified that you are unsure whether you will claim any dependents in 2017, the subject eligibility determination relied upon the information in your application. Therefore, the Appeals Unit will rely on that information in reviewing the determination under review. According to the information in your July 18, 2017 application, you are in a two-person tax household.

According to your account, you reside in [redacted] where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $34,939.84 is 218.10% of the 2016 FPL for a two-person household. At 218.10% of the FPL, the expected contribution to the cost of the health insurance premium is 7.07% of income, or $205.85 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 ($205.85 per month), which equals $250.61 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you eligible for up to $251.00 per month in APTC.

The second issue is whether you were properly found eligible for cost-sharing reductions. Cost-sharing reductions are available to applicants with household income no greater than 250% of the FPL. Since a household income of $34,939.84 is 218.10% of the applicable FPL, NYSOH correctly found you eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined you were ineligible for the Essential Plan, effective September 1, 2017.

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,020.00 for a two-person household. Since an annual household income of $34,939.84 is 218.10% of the 2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined you were ineligible for Medicaid.

Medicaid can be provided through NYSOH to adults between the ages of 19 and 65 who meet the non-financial requirements and have a household modified adjusted gross income that is at or below 138% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $16,240.00 for a two-person household. Since $34,939.84 is 215.15% of the 2017 FPL, NYSOH properly found you ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

Although there is no documentation of your income for the month of May in the record and your testimony as well as the information in your application indicated that the income you received from your second job was inconsistent, you testified that the income you receive from your primary employment with [redacted]

[redacted] is consistent. You testified that you earn $13.03 per hour and work 40 hours per week at that job for an annual income of $27,102.40. Thus, based on your testimony, you would have earned $521.20 for each of the four weeks in May 2017 at your primary job for a total monthly gross income of, at least, $2,084.80.

To be eligible for Medicaid, you would need to meet the non-financial criteria and have an income no greater than 138% of the FPL, which is $1,868.00 per month. Since the evidence establishes you earned, at least, $2,084.80 in May 2017 you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the July 19, 2017 eligibility determination properly stated that, based on the information you provided, you were eligible for up to $251.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The July 19, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 15, 2017

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

This decision does not affect subsequent eligibility determinations.

You were eligible for up to $251.00 in APTC, effective September 1, 2017.

You were eligible for cost-sharing reductions, effective September 1, 2017.

You were ineligible for the Essential Plan, effective September 1, 2017.

You were ineligible for Medicaid, effective September 1, 2017.

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.

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).

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

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Summary

The July 19, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

This decision does not affect subsequent eligibility determinations.

You were eligible for up to $251.00 in APTC, effective September 1, 2017.

You were eligible for cost-sharing reductions, effective September 1, 2017.

You were ineligible for the Essential Plan, effective September 1, 2017.

You were ineligible for Medicaid, effective September 1, 2017.

Legal Authority

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

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.

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).

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।

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 नि:शुल्क 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.

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).

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.

(Yiddish) אידיש

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).