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

Notice of Decision

Decision Date: November 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021525

[redacted]

[redacted]

On October 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 17, 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 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021525

[redacted]

Issues

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

> Did NY State of Health (NYSOH) properly determine that you and your son were eligible to receive up to $551.00 per month in advance payments of the premium tax credit (APTC), effective October 1, 2017?
>
> Did NYSOH properly determine that you and your son were eligible for cost-sharing reductions?
>
> Did NYSOH properly determine that you and your son were not eligible for the Essential Plan?
>
> Did NYSOH properly determine you and your son were not eligible for Medicaid?

Procedural History

On August 16, 2017, you updated your application for financial assistance. That day, a preliminary eligibility determination was prepared stating that you and your son were eligible to receive up to $551.00 per month in APTC and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective October 1, 2017.

Also on August 16, 2017, you spoke to NYSOH's Account Review Unit and appealed, insofar as you and your son were not eligible for a higher level of

financial assistance. You also requested Aid to Continue, pending the outcome of your appeal.

On August 17, 2017, NYSOH issued a notice of eligibility determination, based on the August 16, 2017 application, stating that you and your son were eligible to receive up to $551.00 in APTC, and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective October 1, 2017. That notice also stated that you and your son were not eligible for Medicaid or the Essential Plan because your income was over the allowable income limits for those programs.

Also on August 17, 2017, NYSOH issued a notice of enrollment confirmation, confirming you and your son's enrollment in a Fidelis bronze-level qualified health plan with a monthly premium of $72.96 after the application of your APTC, beginning October 1, 2017.

On August 22, 2017, NYSOH issued a notice of eligibility determination stating that you and your son were eligible for Medicaid for a limited time, effective October 1, 2017. This was because your request for Aid to Continue was granted, pending the outcome of your appeal.

On August 26, 2017, NYSOH issued a notice of enrollment confirmation, confirming you and your son's enrollment in a Medicaid Managed Care plan, beginning October 1, 2017. This was also because your request for Aid to Continue was granted, pending the outcome of your appeal.

On October 12, 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 through October 27, 2017, to allow you to submit supporting documents.

On October 25, 2017, you uploaded documentation to your NYSOH account. 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 head of household with qualifying individual. You will claim one dependent on that tax return.

2) You are seeking insurance for yourself and your son.

3) The application that was submitted on August 16, 2017 listed annual household income of $36,427.86, consisting of $28,939.86 you expect to

earn from self-employment, and $7,488.00, you expect your son to earn from employment.

4) You testified that the income amount you provided was taken from your 2016 tax return, and that you expect your gross income to be approximately the same, or a little less, this year.

5) You testified that you have not been able to work as much because of a [redacted] that you had in October 2016, and that your business has been slow on top of that.

6) You testified that you are a [redacted], and that you do not file quarterly income tax statements, but that you are on a tax payment plan at this time because you owe [redacted] in [redacted].

7) You testified that you have many expenses every month such as electric, rent, internet, and cable, and that you have to pay $600.00 per month toward your daughter's student loan per a divorce decree.

8) You testified that your net business income in the month of August 2017, after business expenses were deducted, was $3,735.00

9) You testified that your son is a full-time college student, and that he has a part-time [redacted] job.

10) You testified that your son earns about $12.00 an hour, and works ten to fifteen hours per week, but that he does not really contribute that income toward household expenses.

11) You testified that you and your son will determine whether he is filing a tax return once he receives his W2 for 2017.

12) You testified that you will be unable to work for approximately four weeks in November 2017 because you are [redacted].

13) After the hearing, you uploaded the following documentation to your NYSOH account:

1. A copy of your signed 2016 IRS Form 1040, with Schedules C and SE, and Form 8962, indicating that your adjusted gross income was $28,939.86 in 2016 [redacted]

2. A copy of a letter from the New York Spine Institute stating that you are having [redacted] on [redacted], and that you will be unable to return to work for a minimum of six to twelve weeks after [redacted]

3. A copy of an invoice from the IRS dated September 20, 2017 and indicating that you owe the IRS a total of $13,258.32 [redacted]

14) Your application states that you live in [redacted]

15) You testified that you cannot afford the costs and the deductible associated with a qualified health plan, and that you need something more affordable.

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

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 (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 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 (81 Fed. Reg. 4036).

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 (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(MAGI) 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.

Dependent Income

With regard to eligibility for financial assistance through NYSOH, a tax filer's household income includes the MAGI of all the individuals in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.36B-1(e)(1); 42 CFR § 435.603(d)(1)). The MAGI-based income of a

child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

A person is not required to file a tax return if their gross income is less than the sum of the exemption amount plus the basic standard deduction allowable for that person (26 USC § 6012(1)(A)). For the 2016 year, a dependent who had yearly gross earned income greater than $6,300.00 or gross unearned income greater than $1,050.00 would be required to file a tax return (see IRS Publication 929 (2016)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your son were eligible for an APTC of up to $551.00 per month.

The application that was submitted on August 16, 2017 listed an annual household income of $36,427.86, and the eligibility determination relied upon that information.

During the hearing, you testified that the amount of income you provided in your application was based on your earnings from last year, and that you expect your earnings this year to be similar. After the hearing, you provided a copy of your 2016 federal income tax return, which confirmed that your adjusted gross income for 2016 was $28,939.86. You also testified that the amount listed for your son's income was based on a part-time job that he has, but that he does not generally contribute to the household.

Eligibility for financial assistance through NYSOH is based on a household's MAGI, which is a household's 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.

A tax filer's household income includes the MAGI of all individuals in the tax filer's household. The earned income of a dependent child will not be considered, unless that child earns enough to be required to file a tax return. In 2016, a dependent who earned more than $6,300.00 in gross income was required to file a tax return.

Your application indicates that your son is expected to earn $7,488.00 in 2017. Since this amount is over $6,300.00, he will likely be required to file a tax return, and his income is therefore included for purposes of determining your household's eligibility for financial assistance through NYSOH.

During the hearing, you asked that your current expenses, which include rent, electricity and other living expenses, be considered when determining your eligibility for financial assistance. However, since the Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable and phone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, based on your testimony and the information in your NYSOH account, NYSOH correctly determined your household income to be $36,427.86.

You are in a two-person household. You expect to file your 2017 income taxes as head of household, and will claim one dependent on that tax return.

You reside in Kings County, where the second lowest cost silver plan available for a primary subscriber and one dependent through NYSOH costs $775.97 per month.

An annual income of $36,427.86 is 227.39% of the 2016 FPL for a two-person household. At 227.39% of the FPL, the expected contribution to the cost of the health insurance premium is 7.41% of income, or $224.94 per month.

The maximum amount of APTC that can be approved equals the cost of the second lowest cost silver plan available through NYSOH for a primary subscriber plus one dependent in your county ($775.97 per month) minus your expected contribution ($224.94 per month), which equals $551.03 per month. Therefore, rounding to the nearest dollar, NYSOH properly found you and your son to be eligible for up to $551.00 per month in APTC, based on the information in your August 16, 2017 application.

The second issue under review is whether you and your son 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 $36,427.86 is 227.39% of the applicable FPL, NYSOH correctly found you and your son to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you and your son 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 $16,020.00 for a two-person household. Since an annual household income of $36,427.86 is 227.39% of the 2016 FPL, NYSOH properly found you and your son to be ineligible for the Essential Plan.

The fourth issue under review is whether NYSOH properly determined that you and your son 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 $36,427.86 is 224.31% of the 2017 FPL, NYSOH properly found you and your son to be 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.

You testified that your net income, after expenses, was $3,735.00 in the month of August 2017.

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. The record does not contain any information as to what your son's income was in August 2017. However, you testified that your net income in August 2017 was $3,735.00, which already puts you and your son above the $1,868.00 monthly income limit.

Since the August 17, 2017 eligibility determination properly stated that, based on the information you provided, you and your son were eligible for up to $551.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it was correct and is AFFIRMED.

Decision

The August 17, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: November 16, 2017

How this Decision Affects Your Eligibility

You and your son remain eligible for up to $551.00 in APTC.

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

You and your son are ineligible for the Essential Plan.

You and your son are ineligible for Medicaid.

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

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).

- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The August 17, 2017 eligibility determination notice is AFFIRMED.

You and your son remain eligible for up to $551.00 in APTC.

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

You and your son are ineligible for the Essential Plan.

You and your son are ineligible for Medicaid.

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.

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.

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)

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).