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

# Notice of Decision

Decision Date: December 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023335

[redacted]

Dear [redacted],

On November 28, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's October 11, 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: December 18, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000023335

[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 and your oldest child were eligible to receive up to $504.00 per month in advance premium tax credit and cost sharing benefits, effective November 1, 2017?
>
> Did NY State of Health properly determine that you and your oldest child were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you and your oldest child were not eligible for the Essential Plan?

## Procedural History

On October 7, 2017, NY State of Health (NYSOH) uploaded income documentation to your NYSOH account that you submitted by fax.

On October 10, 2017, NYSOH reviewed the income documentation you submitted and determined it was sufficient to verify your household's income. NYSOH recalculated your household income based on this information, updated the income in your household's application based on this recalculation, and then submitted an application on you and your oldest child's behalf.

On October 11, 2017, NYSOH issued a notice of eligibility determination stating that you and your oldest child were eligible for a tax credit up to $504.00 per month and eligible to receive cost-sharing reductions if you enrolled in a silver level qualified health plan, effective November 1, 2017. That notice also stated

that you and your oldest child were not eligible for the Essential Plan because your income was over the allowable income limits for that program.

On October 13, 2017, you spoke to NYSOH's Account Review Unit and appealed the October 11, 2017 eligibility determination insofar as you and your oldest child were no longer eligible for the Essential Plan.

On October 20, 2017, NYSOH issued a notice stating that you and your oldest child were eligible for the Essential Plan with a $20.00 per month premium for a limited time, effective November 1, 2017. This is because you and your child had been granted Aid to Continue pending the outcome of your appeal.

Also on October 20, 2017, NYSOH issued a notice stating that you and your child were enrolled in an Essential Plan 1 plus Vision and Dental, with a premium of $47.52 per month, effective November 1, 2017.

On November 28, 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 until December 13, 2017, to allow you time to submit paystubs for you and your oldest child for the month of November 2017.

On December 5, 2017, the Appeals Unit received via fax copies of paystubs for you from October 14, 2017 through November 24, 2017, and paystubs for your son from October 15, 2017 through November 25, 2017. 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 head of household. You will claim two dependents on that tax return.

2) You are seeking insurance for you and your oldest child.

3) The October 10, 2017 application submitted by NYSOH on your behalf listed annual household income of $46,842.63. This amount consisted of $35,007.44 from your employment, and $11,835.19 from your oldest child's employment.

4) NYSOH determined the income in your October 10, 2017 based on paystubs you had submitted for yourself and your oldest child.

5) You testified your income was incorrect because you consistently work 40 hours per week, and earn $14.10 per hour, but that sometimes you work overtime and those hours vary, therefore your monthly income varies based on the amount of overtime you work. You testified that you worked more overtime than usual during the months for which you submitted paystubs, so your income for those months was higher than usual.

6) Your paystub for November 11, 2017 through November 24, 2017 shows a year to date gross income $29,588.75.

7) You testified that your oldest child's income was incorrect because he is a full-time student and works fewer hours during the school year than he does during the summer. You testified that the income in your oldest child's paychecks was not an accurate representation of his annual income because the paychecks were from the summer when he worked more hours and therefore earned more than he does the rest of the year. You also testified that in 2017 your oldest child worked at [redacted] and did not have other employment.

8) Your oldest child's paystub from [redacted] dated November 12, 2017 through November 25, 2017 shows a year to date gross income of $6,781.67.

9) Your application states that you will not be taking any deductions on your 2016 tax return.

10) You live in Orange County.

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 $20,160.00 for a three-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 $20,160.00 for a three-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)).

<u>Modified Adjusted Gross Income – Dependent Income</u>

NYSOH bases its eligibility determinations on modified adjusted gross income (MAGI) as defined in the federal tax code (45 CFR § 155.300(a), 42 CFR § 603(e), see 26 USC § 36B(d)(2)(B)).

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 2017 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 Revenue Procedure 2014-61).

Unearned income is generally all income other than salaries, wages and other amounts received as pay for work actually performed, including the taxable part of Social Security and pension payments (IRS Publication 929, pg 15).

For the purposes of determining a person's eligibility for financial assistance for health insurance through NYSOH, the term "MAGI" 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)).

## Legal Analysis

The first issue is whether NYSOH properly determined that you and your oldest son were eligible for an APTC of up to $504.00 per month.

On October 7, 2017, NYSOH uploaded income documentation to your NYSOH account that you submitted by fax. On October 10, 2017, a NYSOH representative reviewed the income documentation you submitted and recalculated the household income based on that documentation. An application for financial assistance was submitted on you and your oldest child's behalf by a NYSOH representative. The NYSOH representative entered into your application an earned income of $35,007.44 for you, and $11,835.19 for your oldest child, for a total annual household income of $46,842.63 and the eligibility determination relied on that information.

You are in a three-person household. You expect to file your 2017 income taxes as head of household and will claim 3 dependents on that tax return.

You reside in Orange County, where the second lowest cost silver plan available for a primary subscriber with one dependent seeking enrollment in a qualified health plan through NYSOH costs $800.12 per month.

An annual income of $46,842.63 is 232.35% of the 2016 FPL for a three-person household. At 232.35% of the FPL, the expected contribution to the cost of the health insurance premium is 7.58% of income, or $295.88 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 primary subscriber

with one dependent in your county ($800.12 per month) minus your expected contribution ($295.88 per month), which equals $504.24 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you and your oldest child to be eligible for up to $504.00 per month in APTC.

The second issue is whether you and your oldest child 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 $46,842.63 is 232.35% of the applicable FPL, NYSOH correctly found you and your oldest child eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined that you and your oldest child were not eligible 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 $20,160.00 for a three-person household. Since an annual household income of $46,842.63 is 232.35% of the 2016 FPL, NYSOH properly found you and your oldest child ineligible for the Essential Plan.

Accordingly, the October 11, 2017 eligibility determination notice is AFFIRMED because based on the information available at the time, NYSOH properly found you and your oldest child to be eligible for $504.00 in advance premium tax credits and cost sharing reductions effective November 1, 2017, and ineligible for the Essential Plan.

However, you testified that the annual household income of $46,842.63, consisting of $35,007.44 from your employment, and $11,835.19 from your child's employment, was incorrect because the income documentation that it was based on included overtime that you do not typically work every pay period. You submitted evidence that corroborated your testimony.

You provided paystubs from your employment that show that as of November 24, 2017, your gross income was $29,588.75. Since there are 52 weeks in a year, and your average pay is $629.54 per week, your 2017 gross income is $32,736.08.

A dependent is required to file a tax return for 2017 when their earned income is greater than $6,300.00. You submitted paystubs from your oldest child's employment at [redacted] that show a gross income of $6,781.67 as of November 25, 2017. Since there are 52 weeks in a year, and your child's average pay is $144.29 per week, your child's 2017 gross income is $7,503.08. A gross annual income of $7,503.07 is greater than $6,300.00, so your oldest child

would be required to file a tax return and his income is therefore included in you household's income.

Since the record now contains a more accurate representation of you and your oldest child's income for 2017, your case is RETURNED to NYSOH to redetermine you and your oldest child's eligibility based on a household size of three people and a household income of $40,239.16.

## Decision

The October 10, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to redetermine your and your oldest son's eligibility for financial assistance with an annual expected income of $40,239.16, , for a household size of three, residing in Orange County.

## **Effective Date of this Decision:** December 18, 2017

## How this Decision Affects Your Eligibility

NYSOH was proper to determine you and your oldest child eligible for $504.00 in APTC, cost-sharing reductions, and ineligible for the Essential Plan based on the information available in your NYSOH account at that time.

This is not a final determination of your eligibility for financial assistance. Your case is being sent back to NYSOH to redetermine your and your oldest child's eligibility based on the information you submitted during your hearing.

## 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 October 10, 2017 eligibility determination notice is AFFIRMED.

NYSOH was proper to determine you and your oldest child eligible for $504.00 in APTC, cost-sharing reductions, and ineligible for the Essential Plan based on the information available in your NYSOH account at that time.

Your case is RETURNED to NYSOH to redetermine your and your oldest son's eligibility for financial assistance with an annual expected income of $40,239.16, , for a household size of three, residing in Orange County.

This is not a final determination of your eligibility for financial assistance. Your case is being sent back to NYSOH to redetermine your and your oldest child's eligibility based on the information you submitted during your hearing.

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## Legal Authority

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

## A Copy of this Decision Has Been Provided To:

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)**

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).

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 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).

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