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

Notice of Decision

Decision Date: February 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024113

[redacted]

[redacted]

On January 22, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 24, 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: February 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000024113

[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 $261.00 per month in advance payment of the premium tax credit, effective December 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 not eligible for the Essential Plan?
>
> Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

According to your NY State of Health (NYSOH) account, you updated your application for financial assistance on October 20, 2017. Pursuant to NYSOH's request you submitted two consecutive bi-weekly paystubs from your employer, dated September 29, 2017 and October 13, 2017 (*see* Documents [redacted] and [redacted].

On October 24, 2017, NYSOH issued an eligibility determination notice, based on the information contained in those paystubs, stating that you were eligible to

receive up to $261.00 in advance payment of the premium tax credit (APTC) and eligible to receive cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective December 1, 2017. The notice also stated that you were not eligible for the Essential Plan or Medicaid because your income was over the allowable income limit for those programs.

On November 4, 2017, you submitted your bi-weekly paystub, dated October 27, 2017 [redacted].

Also on November 4, 2017, you submitted a written appeal request to NYSOH's Account Review Unit and appealed the eligibility determination insofar as it did not find you eligible for additional financial assistance [redacted]

On January 22, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open until February 6, 2018, to allow you time to submit supporting documentation.

On February 6, 2018, you submitted a copy of your 2017 W-2 Wage Statements from your two employers [redacted]. These documents were made part of the record as "Appellant's Exhibit A." The record closed that day.

Findings of Fact

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

1) According to your NYSOH account and your testimony, you expect to file your 2017 taxes with a tax filing status of single. You will claim no dependents on that tax return.

2) You are seeking health insurance with additional financial assistance for yourself.

3) On October 23, 2017, NYSOH systematically updated your application based on the income documents you provided. That application listed annual household income of $29,184.88, consisting of $29,184.88 you earn from your employment. You testified that this is incorrect because as of August 2017, you changed employers and that you are working fewer hours. You only work for [redacted] and expect to have a 2017 total gross annual income of $20,000.00.

4) On February 6, 2018, you submitted your two W-2 Wage Statements for 2017, which show that your modified adjusted gross income for 2017 was

$30,076.03, consisting of $7,012.90 in gross income less a 401(k) deduction of $222.01 for a total of $6,790.89 in gross federal taxable wages you received from [redacted] and $24,835.30 in gross income less a 401(k) and [redacted] deductions of $1,550.16 for a total of $23,285.14 in gross federal taxable wages you received from [redacted] (*see* Appellant's Exhibit A, pp. 2-3). These documents do not show that you stopped working for [redacted] in August 2017.

5) You submitted copies of your paystubs from [redacted] dated October 13, 2017 and October 27, 2017, which shows that in the month of October 2017, you received $1,460.27 in employment income from that employer, consisting of $1,500.16 in gross income less a 401(k) deduction of $39.89.

6) According to your NYSOH account, and your testimony, you live in [redacted], New York.

Conflicting evidence, if any, was considered and found to be less credible than the evidence noted above.

Applicable Law and Regulations

Gross Income - Elective Salary Contributions

Generally, gross income includes all income from whatever source derived, including but not limited to compensation, business income, interest, dividends, annuities, alimony, pensions, life insurance income, and income from an estate or trust (*see* 26 USC § 61). However, the Internal Revenue Code allows for exclusion of contributions made to specific qualified plans, including but not limited to 401(k) plans and cafeteria plans, from an individual's gross income if that individual and the employer meets certain minimum requirements (26 USC § 401 and IRS Publication 560, *and see* 26 USC § 402(g) and IRS Notice 2017-64; *see* also 26 U.S. Code § 125, *and see* 26 U.S. Code § 3121 (a)(5)(G) and IRS Publication 560).

Advance Payments of Premium Tax Credit

Advance payments of the premium tax credit are generally available to a person who is eligible to enroll in a qualified health plan 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 in 2017 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).

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 $11,880.00 for a one-person household (81 Fed. Reg. 4036).

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

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 $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).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you were eligible for an APTC of up to $261.00 per month in APTC, effective December 1, 2017.

The application that was submitted on October 23, 2017, listed annual household income of $29,184.88, consisting of $29,184.88 you earn from your employment. NYSOH relied on this information.

However, you testified that this is incorrect because you changed employers in August 2017 and your income is now less. You further testified you expect to have a total 2017 gross annual income of $20,000.00. As such, the record was held open to allow you time to submit supporting documents.

Although you did submit your 2017 W-2 Wage Statements from your two employers, you did not submit any proof that you no longer work for [redacted], and therefore, for purposes of these analyses, NYSOH properly determined your annual modified adjusted gross income to be $29,184.88 based on the income documentation you provided, which is $29,185.00 rounded to the nearest dollar.

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

According to your NYSOH account, and your testimony, you live 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 $29,185.00 is 245.66% of the 2016 FPL for a one-person household. At 245.66% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 8.06% of income, or $195.92 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 ($195.92 per month), which equals $260.53 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $261.00 per month in APTC, based on the information you provided in your application.

The second issue under review 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 $29,184.88 is 245.66% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions, based on the information you provided in your application.

The third issue under review is whether NYSOH properly determined that you 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 $11,880.00 for a one-person household. Since an annual household income of $29,184.88 is 245.66% of the

2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan, based on the information you provided in your application.

The fourth issue under review is whether NYSOH properly determined that you were not eligible 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 $12,060.00 for a one-person household. Since $29,185.00 is 242% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, based on the information you 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 submitted copies of your paystubs which shows that in the month of October 2017, you received $1,460.27 in employment income from [redacted] Although you failed to provide proof that you no longer work for your second employer, [redacted]; for purposes of this analysis, your income is considered to be at least $1,460.27 in the month of October 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 $1,387.00 per month. Since the documentation you provided shows that you earned at least $1,460.27 in October 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the October 24, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for $261.00 in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The October 24, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 13, 2018

How this Decision Affects Your Eligibility

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 were properly determined eligible for up to $261.00 per month in APTC in 2017.

You were properly determined eligible for cost-sharing reductions in 2017.

You were properly determined ineligible for the Essential Plan in 2017.

You were properly determined ineligible for Medicaid on both an annual and monthly basis.

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 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).

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 24, 2017 eligibility determination notice is AFFIRMED.

You were properly determined eligible for up to $261.00 per month in APTC in 2017.

You were properly determined eligible for cost-sharing reductions in 2017.

You were properly determined ineligible for the Essential Plan in 2017.

You were properly determined ineligible for Medicaid on both an annual and monthly basis.

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)

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।

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).

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.

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).