

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

## Notice of Decision

Decision Date: February 21, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024943

[REDACTED]

[REDACTED]

On February 8, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's October 28, 2017 renewal 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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### Decision

Decision Date: February 21, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000024943

[REDACTED]  
[REDACTED]  
[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 \$458.07 per month in advance payments of the premium tax credit, effective January 1, 2018?

Did NY State of Health properly determine that you were eligible for cost-sharing reductions?

Did NY State of Health properly determine that you were ineligible for the Essential Plan?

Did NY State of Health properly determine that you were ineligible for Medicaid?

### Procedural History

On October 28, 2017, NYSOH issued renewal notice stating that you were eligible to receive up to \$458.07 per month in advance payments of the premium tax credit (APTC) as well as cost-sharing reductions if you enrolled in a silver level qualified health plan, both effective January 1, 2018. That notice also stated that you were not eligible for the Essential Plan or Medicaid because your annual household income was over the allowable income limits for those programs.

On November 28, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not eligible for Medicaid.

On January 25, 2018, you were scheduled for a telephone hearing with a Hearing Officer from the NYSOH Appeals Unit. You requested that day that the hearing be adjourned to a later date.

On February 8, 2018, you had an adjourned telephone hearing with a Hearing Officer from the NYSOH Appeals Unit. Under oath, you waived your right to formal notice of the hearing. The record was developed during the hearing and held open until February 15, 2018, to allow you time to submit supporting documents.

On February 8, 2018, you uploaded four paystubs to your NYSOH account. These documents were incorporated into the record and the record was closed.

## **Findings of Fact**

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

- 1) You testified that you expect to file your tax return for 2018 with a tax filing status of single. You will claim no dependents on that tax return.
- 2) You are seeking insurance for yourself.
- 3) The application that was submitted on October 28, 2017 listed annual household income of \$26,882.81, consisting of \$28,682.81 you earn from your employment, less \$1,800.00 in student loan interest deductions. You testified that this amount was correct, except that you believe you will claim between \$2,600.00 and \$2,800.00 in deductions for student loan interest.
- 4) You testified that you are paid on a weekly basis and that your pay varies from week to week and decreases or increases depending on the season.
- 5) On February 8, 2018, you uploaded four paystubs to your NYSOH account; the first is for pay date October 6, 2017 for a gross amount of \$409.43; the second is for pay date October 13, 2017 for a gross amount of \$732.22; the third is for pay date October 20, 2017 for a gross amount of \$604.92; the fourth is for pay date October 27, 2017 for a gross amount of \$630.71.
- 6) You provided documentation, that your monthly income for October 2017 was \$2,377.28.

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- 7) You testified that you will not be taking any deductions on your 2018 tax return other than a deduction for student loan interest.
- 8) Your application states, and you confirmed, that you live in Orange County.
- 9) You testified that you have bills including rent of \$1,250.00 per month, utilities of approximately \$150.00 per month, car payments of \$450.00 per month, as well as your grandmother's phone bill of \$50.00 per month, and weekly groceries for your grandmother, that you would like considered when determining your eligibility for financial assistance with health insurance.

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 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (see 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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

2018 is set by federal law at 2.01% to 9.56% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3, IRS Rev. Proc. 2017-36).

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 2017 FPL, which is \$12,060.00 for a one-person household (82 Federal Register 8831).

For annual household income in the range of at least 200% but less than 250% of the 2017 FPL, the expected contribution is between 6.34% and 8.10% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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 qualified health plan 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 qualified health plan (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 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

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CFR § 155.300(a)). 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).

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/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 \$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 funds from tax savings accounts, deductions attributable to royalties, certain retirement savings, and interest on qualified educational loans (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id.*).

Subject to some limitations, interest on a qualified educational loan can be deducted from adjusted gross income in an amount up to \$2,500 in interest paid by taxpayers during the taxable year, whose yearly income does not exceed \$160,000 (26 USC § 221; see also 26 USC §62(17)).

## **Legal Analysis**

The first issue is whether NYSOH properly determined that you were eligible for up to \$458.07 per month in APTC.

The application that was submitted on October 28, 2017 listed an annual household income of \$26,882.81 and the eligibility determination relied upon that information.

During the hearing, you testified that the amount you provided in your application was correct. However, you asked that your current expenses, which include rent, utilities, your car payment, and other living expenses, be considered when determining your eligibility for financial assistance.

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 NYSOH computes your modified adjusted gross income. Therefore, NYSOH correctly determined your household income to be \$26,821.81.

You expect to file your 2018 income tax return as single and will not claim any dependents on that tax return. Therefore, you are in a one-person household.

You reside in Orange County, where the second lowest cost silver plan available for an individual through NYSOH costs \$618.25 per month.

An annual income of \$26,882.81 is 222.91% of the 2017 FPL for a one-person household. At 222.91% of the FPL, the expected contribution to the cost of the health insurance premium is 7.15% of income, or \$160.10 per month.

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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 (\$618.25 per month) minus your expected contribution (\$160.10 per month), which equals \$458.15 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$458.00 per month in APTC.

The second issue is whether you were properly determined 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 \$26,882.81 is 222.91% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions.

The third issue under review is whether NYSOH properly determined you were ineligible for the Essential Plan.

The Essential Plan is generally 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 \$26,882.81 for a one-person household. Since an annual household income of \$26,882.21 is 222.91% of the 2017 FPL, NYSOH correctly found you to be ineligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined that 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 \$12,060.00 for a one-person household. Since \$26,882.21 is 222.91% of the 2017 FPL, NYSOH properly found you to be eligible 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 submitted paystubs that shows in October 2017 you received \$2,377.28.

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 \$2,377.28 in

October 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the October 28, 2017 renewal notice properly stated that, based on the information you provided, you were eligible for up to \$458.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

During the hearing, you testified that you will be claiming between \$2,600.00 and \$2,800.00 in deductions for student loan interest on your 2018 tax return. However, the IRS only deducts interest on qualified student loans from a person's adjusted gross income in an amount of up to \$2,500.00. Since the IRS does not allow for a student loan interest deduction in excess of \$2,500.00, neither can NYSOH when calculating your modified adjusted gross income for the purposes of determining your eligibility for financial assistance.

Therefore, your case is RETURNED to NYSOH redetermine your eligibility for financial assistance based on a household of one residing in Orange County with an annual expected income of \$26,182.81 (\$28,862.81 less \$2,500.00 in deductions).

## **Decision**

The October 28, 2017 renewal notice is AFFIRMED.

Your case is RETURNED to NYSOH redetermine your eligibility for financial assistance based on a household of one residing in Orange County with an annual expected income of \$26,182.81.

**Effective Date of this Decision:** February 21, 2018

## **How this Decision Affects Your Eligibility**

You remain eligible for up to \$458.00 in APTC.

You are eligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You are ineligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your eligibility based on information you provided during your hearing.

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 Disagree with this Decision (Appeal Rights)**

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 28, 2017 renewal notice is AFFIRMED.

You remain eligible for up to \$458.00 in APTC.

You are eligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You are ineligible for Medicaid.

Your case is being sent back to NYSOH to redetermine your eligibility based on information you provided during your hearing.

Your case is RETURNED to NYSOH redetermine your eligibility for financial assistance based on a household of one residing in Orange County with an annual expected income of \$26,182.81.

## **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]  
[REDACTED]  
[REDACTED]

## **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 महत्वपूर्ण 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 ye tow krataa a ho hia. Se wo hia eho nkyerekyeremu a, ye sre wo, fre 1-855-355-5777. ye&btumi ama wo obi a okyerE 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 کرم 1-855-355-5777 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.