STATE OF NEW YORK
DEPARTMENT OF HEALTH
PO Box 11729
Albany, NY 12211

Notice of Decision

Decision Date: March 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025624

[redacted]

Dear [redacted]

On February 14, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 12, 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
  PO 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: March 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP0000000025624

[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 you were eligible to receive up to $286.00 in monthly advance payments of the premium tax credit (APTC), for a limited time, effective January 1, 2018?
>
> Did NYSOH properly determine you were not eligible for cost-sharing reductions?
>
> Did NYSOH properly determine you were not eligible for the Essential Plan?

Procedural History

On September 1, 2017, NYSOH received your updated application for financial assistance with health insurance.

On September 2, 2017, NYSOH issued a notice of eligibility determination stating you were eligible for the Essential Plan with a $20.00 monthly premium, for a limited time, effective October 1, 2017. You were directed to provide proof of income by November 30, 2017. You were subsequently enrolled in the Essential Plan.

No income documentation was received, and on December 5, 2017, NYSOH redetermined your eligibility.

On December 6, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $249.00 per month in APTC, effective January 1, 2018, and ineligible for the Essential Plan.

On December 11, 2017, NYSOH received your updated application for financial assistance with health insurance. A preliminary determination was prepared that day finding you eligible to receive up to $286.00 per month in APTC.

Also on December 11, 2017, you spoke to NYSOH's Account Review Unit and appealed that determination insofar as you were not eligible for more financial assistance.

On December 12, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $286.00 per month in APTC, effective January 1, 2018, for a limited time. The notice indicated that you were not eligible for the Essential Plan, cost-sharing reductions, and Medicaid, because your income was over the allowable limit for those programs. You were directed to provide proof of income by March 11, 2018.

On February 14, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed and held open until February 23, 2018, to allow you to provide income documentation. Such documentation was received on February 16, 2018, and the record was closed.

Findings of Fact

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

1) On September 1, 2017 you submitted an updated application that listed your attested annual income as $22,360.00. On December 11, 2017, you submitted an updated application that listed your attested annual income as $31,668.00.

2) You testified that you have two jobs. You earn $1,384.62 every two weeks through your employment with [redacted] and about $288.00 every two weeks from other, part-time employment, with the [redacted], for which you are paid $11.00 per hour. Your application indicated that you had recently started this second, part-time job.

3) Your application indicated that you will file your 2018 tax return with a tax filing status of single and you will claim no dependents.

4) Based on the information in your December 11, 2017 application, which included expected annual earnings of $31,668.00, NYSOH determined you were eligible to receive up to $286.00 per month in APTC, effective

January 1, 2018. You were no longer eligible for the Essential Plan and you were not eligible for cost-sharing reductions.

5) You appealed insofar as you were not eligible for more financial assistance.

6) Your December 11, 2017 application indicates you will not take any deductions on your tax return.

7) You testified that you cannot afford health insurance with the level of financial assistance you currently receive, and that your expenses include rent, child support, utilities, telephone, transportation expenses, and insurance.

8) After the hearing, you submitted income documentation on February 16, 2018. This included two consecutive paystubs dated January 11, 2018 and January 25, 2018, with gross amounts of $377.00 and $389.25 respectively, from your employment with [redacted]. Both stubs indicated that you worked 29 hours during a two-week period, but your rate of pay increased from $13.00 to $13.42 per hour in the later pay period. The first pay stub appears to show that it was your first income from that entity. The income documentation also included two consecutive paystubs dated January 5, 2018 and January 19, 2018, both for a gross amount of $1,384.62, from your employment with [redacted].

9) Your application indicates you live in Kings County.

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

Applicable Law and Regulations

Modified Adjusted Gross Income

NYSOH bases its eligibility determinations on modified adjusted gross income as defined in the federal tax code (45 CFR § 155.300(a)). The term "modified adjusted gross income" means adjusted gross income increased by (1) any income that was excluded under 26 USC § 911 for United States citizens or residents living abroad, (2) tax-exempt interest received or accrued, and (3) Social Security benefits that were excluded from gross income under 26 USC § 86 (*see* 26 USC § 36B(d)(2)(B), 26 CFR § 1.36B-1(e)(2)).

"Adjusted gross income" means, in the case of an individual taxpayer, gross federal taxable income minus certain specific deductions, such as expenses

reimbursed by an employer, losses from sale or exchange of property, losses from premature withdrawal of finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id*.).

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 from 138% up to 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 250% but less than 300% of the 2017 FPL, the expected contribution is between 8.10% and 9.56% 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 Eligibility

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 2017 FPL, which is $12,060.00 for a one-person household (82 Fed. Reg. 8831).

Legal Analysis

The first issue is whether NYSOH properly determined you were eligible to receive up to $286.00 in monthly APTC, effective January 1, 2018, for a limited time.

The application submitted on December 11, 2017 listed an annual household income of $31,668.00, and NYSOH relied on that representation.

You are in a one-person household, because you file your income tax return with a tax filing status of single and you claim no dependents.

You reside in Kings County, where the second lowest cost silver plan available for an individual through NYSOH costs $509.30 per month.

An annual income of $31,668.00 is 262.59% of the 2017 FPL for a one-person household. At 262.59% of the FPL, the expected contribution to the cost of the health insurance premium is 8.47% of income, or $223.52 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 ($509.30 per month) minus your expected contribution ($223.52 per month), which equals $285.78 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you eligible for up to $286.00 per month in APTC.

The second issue is whether you were properly determined ineligible 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 $31,668.00 is 262.59% of the applicable FPL, over the 250% limit, NYSOH correctly found you ineligible 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 $12,060.00 for a one-person household. Since an annual household income of $31,668.00 is 262.59% of the 2017 FPL, NYSOH correctly found you ineligible for the Essential Plan.

During the hearing, you testified that you have various personal expenses that should be considered when determine your eligibility for financial assistance with health insurance. However, according to the above cited regulations, eligibility for financial assistance through NYSOH is based on modified adjusted gross income as defined in the federal tax code. Since Internal Revenue Service rules do not allow living expenses such as rent, utilities, child support, and telephone to be deducted from the calculation of your adjusted gross income, they cannot be deducted when NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, NYSOH properly determined the eligibility of you and your child for financial assistance with health insurance based on an annual income of $31,668.00, as listed in your application.

However, after the hearing you provided documentary evidence regarding your expected income for 2018. Although your application listed annual expected earnings for 2018 to be $31,668.00, the documentation showed that you started a second, part-time job in January 2018, from which you earned $766.25 for two, two-week periods in January 2018. Averaging that amount over 26 paychecks equals annual earnings from that job of $9,961.25. The documentation from your primary employment indicates you earn $1,384.62 every two weeks, for an annual total of $36,000.12.

The Appeals Unit finds, based on your income documentation, that your expected annual household income for 2018 is therefore $45,961.37, and your case is returned to NYSOH to make a final determination as to your financial eligibility for the remainder of 2018.

Decision

The December 12, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 20, 2018

How this Decision Affects Your Eligibility

You remain temporarily eligible to receive up to $286.00 per month in APTC. HOWEVER, your case is being returned to NYSOH for a redetermination of your eligibility based on your income documentation, and this level of assistance may change.

PLEASE NOTE: Any APTC you receive for 2018 must be reconciled on your 2018 federal income tax return. Be advised that enrollees who take more tax credit in advance than they eventually can claim on their tax return for that year will owe the difference as additional income tax.

You remain ineligible for cost-sharing reductions and Essential Plan.

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 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
  PO Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The December 12, 2017 eligibility determination notice is AFFIRMED.

You remain temporarily eligible to receive up to $286.00 per month in APTC. HOWEVER, your case is being returned to NYSOH for a redetermination of your eligibility based on your income documentation, and this level of assistance may change.

PLEASE NOTE: Any APTC you receive for 2018 must be reconciled on your 2018 federal income tax return. Be advised that enrollees who take more tax credit in advance than they eventually can claim on their tax return for that year will owe the difference as additional income tax.

You remain ineligible for cost-sharing reductions and Essential Plan.

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।

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 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).