



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

Notice of Decision

Decision Date: March 15, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025648

[REDACTED]

Dear [REDACTED],

On February 20, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 18, 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
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Decision

Decision Date: March 15, 2018

NY State of Health Account ID: [REDACTED]
Appeal Identification Number: AP000000025648



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 \$312.00 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 not eligible for the Essential Plan?

Did NY State of Health properly determine that you were not eligible for Medicaid?

Procedural History

On November 18, 2017, NY State of Health (NYSOH) issued an eligibility determination notice, based on your November 17, 2017 application, stating that you were eligible to receive up to \$312.00 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 January 1, 2018. That notice also stated that you were not eligible for the Essential Plan or Medicaid because your income was over the allowable income limits for those programs.

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On December 12, 2017, you spoke to NYSOH's Account Review Unit and appealed the amount of your financial assistance.

On February 20, 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 to March 7, 2018, to allow you to submit supporting documents.

On February 28, 2018, you submitted your 2017 federal and state income tax returns, a self-attestation letter dated February 26, 2018, weekly paystubs from your primary employer, dated November 3, 2017 through December 1, 2017 and February 23, 2018, and weekly paystubs from your secondary employer, dated November 17, 2017 through December 8, 2017 and February 23, 2018. These documents were made part of the record and marked "Appellant's Exhibit A."

As of March 7, 2018, the Appeals Unit did not receive any additional documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that day.

Findings of Fact

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

- 1) According to your NYSOH account, you expect to file your 2017 taxes with a tax filing status as single and will claim no dependents on that tax return.
- 2) You testified that although you expect to file your 2017 taxes with a tax filing status of single, you will claim your two grandchildren as dependents on that tax return.
- 3) You submitted your 2017 federal income tax return which shows that you filed as Head of Household and claimed three dependents on that tax return. Two of those dependents are listed as your grandchildren, the third dependent is listed as your daughter, who is not under the age of 17 (see Appellant's Exhibit A, p. 4).
- 4) You are seeking affordable health insurance for yourself.
- 5) The application that was submitted on November 17, 2017, listed annual household income of \$24,960.00, consisting of earnings from your employment. You testified that this amount was correct.
- 6) Your submitted documentation that shows you received \$27,600.00 in modified adjusted gross income in 2017 (*id.*).

- 7) You also provided documentation that your monthly income for November 2017 was at least \$1,960.24, consisting of \$1,707.24 you received from your primary employer and at least \$253.00 you received from your secondary employer, as follows:

Primary Employer:

11/3/17:	\$ 384.00
11/10/17:	\$ 384.00
11/17/17:	\$ 459.24
11/22/17:	<u>\$ 480.00</u>
Total:	\$1,707.24

Secondary Employer:

11/17/17:	\$ 85.25
11/22/17:	<u>\$ 167.75</u>
Total:	\$ 253.00

(see Appellant's Exhibit A, pp. 24-32)

- 8) You did not testify to claiming your child on your 2017 income tax return. You did not testify to or submit proof of your child's age, student status, or income.
- 9) According to your NYSOH account, testimony, and submitted documentation, you will not be taking any deductions on your 2017 tax return.
- 10) According to your NYSOH account and testimony, you live in Monroe County, New York.

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

Applicable Law and Regulations

Household Composition

For purposes of an eligibility determination, the household size equals the number of individuals for whom the taxpayer is allowed a deduction under 26 USC § 151 for the taxable year, which typically includes: (1) the taxpayer, (2) his or her spouse, and (3) any claimed dependents (42 CFR § 435.603(f)(1)); 26 USC § 36B(d)(1)).

In general, household income means the aggregate modified adjusted gross income of every person who is included in the taxpayer's family and is required to file a federal tax return (26 CFR § 1.36B-1(e)).

The IRS determines whether a qualified dependent is required to file an income tax return based on the amount of the dependent's earned and unearned income, marital status, age, student status and whether that dependent is blind. According to the latest final publication, in cases where the dependent is under the age of 65, not blind and earns an income \$6,350.00 or higher during the 2017 income tax year (or unearned income in the amount of \$1,050 or higher), that dependent is required to file an income tax return for 2017 (IRS Pub. 501).

Requirement for Individuals to Report Changes

NYSOH must require an applicant to report any change which may affect eligibility, such as citizenship status, incarceration, residency, household size, and income within 30 days of such change (45 CFR §155.330(b), 45 CFR §155.305, 42 CFR §435.403, 42 CFR §435.406, 42 CFR §425.603).

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).

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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 8.1 % 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 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).

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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

A person who meets certain nonfinancial criteria and has a household income that is at or below the applicable Medicaid income standard is eligible for Medicaid benefits (45 CFR § 155.305(c)). One of the non-financial criteria for Medicaid eligibility is the immigration status of the person applying for health insurance. A person is eligible for Medicaid when his or her immigration status is satisfactory and he or she meets all other requirements for 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 applications, that was the 2017 FPL, which is \$12,060.00 for a one-person household (82 Federal Register 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 to receive up to \$312.00 per month in advance payments of the premium tax credit, effective January 1, 2018?

According to your NYSOH account, you expect to file your 2017 taxes with a tax filing status as single and will claim no dependents on that tax return. You testified that although you expect to file your 2017 taxes with a tax filing status of single, you will claim your two grandchildren as dependents on that tax return. As

such, the record was kept open to allow you time to submit proof of your income and household size.

However, your submitted documentation conflicts with your testimony and shows that you filed as Head of Household and claimed three dependents on your 2016 tax return. Two of those dependents are listed as your grandchildren, the third dependent is listed as your child, who is not under the age of 17.

Nonetheless, household income consists of the aggregate modified adjusted gross income of every person in the household who is required to file a federal tax return. Since you did not testify to or submit proof of your child's age, student status, or income, we cannot determine whether your child is required to file a federal tax return, and consequently, we cannot determine if that child has income that is required to be reported. Therefore, it is concluded that for purposes of these analyses, you are in a one-person household, as is stated in your application.

You reside in Monroe County, where the second lowest cost silver plan available for an individual through NYSOH costs \$449.11 per month.

An annual income of \$24,960.00 is 206.97% of the 2017 FPL for a one-person household. At 206.97% of the FPL, the expected contribution to the cost of the health insurance premium in 2018 is 6.59% of income, or \$137.07 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 (\$449.11 per month) minus your expected contribution (\$137.07 per month), which equals \$312.04 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$312.00 per month in APTC.

The second issue under review 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 \$24,960.00 is 206.97% 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 \$12,060.00, for a one-person household. Since an annual household income of \$24,960.00 is 206.97%

of the 2017 FPL, NYSOH correctly found you to be ineligible for the Essential Plan.

The fourth issue under review 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 \$24,960.00 is 206.97% of the 2017 FPL, NYSOH properly found you to be ineligible for Medicaid on an expected annual income basis, using the information provided in your application.

However, financial eligibility for Medicaid for applicants who are not currently receiving Medicaid benefits is based on current monthly household income and family size.

You provided documentation that your monthly income for November 2017 was at least \$1,960.24.

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 \$1,960.24 in November 2017, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the November 18, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for up to \$312.00 per month in APTC, eligible for cost-sharing reductions, ineligible for the Essential Plan, and ineligible for Medicaid, it is correct and is AFFIRMED.

Decision

The November 18, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 15, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

You remain eligible for APTC of \$312.00 as of January 1, 2018.

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 are eligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You are ineligible for Medicaid.

It appears that you have had a change in household size and income, based on the information above. If this is the case, you are required to report any such change to NYSOH within 30 days.

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):

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NY State of Health Appeals
P.O. Box 11729
Albany, NY 12211
- By fax: 1-855-900-5557

Summary

The November 18, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

You remain eligible for APTC of \$312.00 as of January 1, 2018.

You are eligible for cost-sharing reductions.

You are ineligible for the Essential Plan.

You are ineligible for Medicaid.

It appears that you have had a change in household size and income, based on the information above. If this is the case, you are required to report any such change to NYSOH within 30 days.

Legal Authority

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

A Copy of this Decision Has Been Provided To:



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 مجاناً.

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 srε wo, frε 1-855-355-5777. ye&εtumi ama wo obi a okyerε 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.

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).