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

Notice of Decision

Decision Date: March 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025906

[redacted]

Dear [redacted]

On February 21, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 16, 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).

This page intentionally left blank.

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

Decision

Decision Date: March 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025906

[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 $142.00 per month in advance payments of the premium tax credit (APTC), effective January 1, 2018?
>
> Did NYSOH properly determine you were not eligible to receive cost-sharing reductions?
>
> Did NYSOH properly determine you were not eligible for the Essential Plan?
>
> Did NYSOH properly determine you were not eligible for Medicaid?

Procedural History

On December 15, 2017, NYSOH received an updated application for financial assistance with health insurance submitted on your behalf. That day a preliminary eligibility determination was prepared finding you eligible to receive up to $142.00 per month in APTC, effective January 1, 2018.

Also on December 15, 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 16, 2017, NYSOH issued an eligibility determination notice stating you were eligible to receive up to $142.00 per month in APTC, effective January 1, 2018. The notice indicated you were not eligible for cost-sharing reductions, the Essential Plan, or Medicaid, because your annual household income was over the allowable income limits for those programs.

On February 21, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed thereafter.

Findings of Fact

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

1) You are seeking insurance for yourself.

2) An updated application was submitted on your behalf on December 15, 2017. That application indicated you expected to file your 2018 tax return with a tax filing status of married filing jointly with your spouse and you would claim no dependents. The application indicated that your spouse was not applying for coverage through NYSOH.

3) The application listed annual expected household income for 2018 of $47,316.00 consisting of monthly Social Security benefits your spouse received in the amount of $2,197.00 as well as monthly pension payments your spouse received in the amount of $1,746.00. The application indicated you had no expected income for 2018.

4) You testified that the information in the December 15, 2017 application was accurate at the time it was filed.

5) NYSOH determined you eligible to receive up to $142.00 in APTC. You appealed insofar as you were not eligible for more financial assistance.

6) You testified that your spouse passed away [redacted].

7) You testified that since your spouse passed away, you do not think you will continue receiving his Social Security benefits and you were unsure if you will continue receiving his pension payments.

8) You testified that your current income situation is unknown and that you have to wait a few weeks and make some phone calls to determine what kind of income you will be receiving in 2018.

9) You testified that you currently do not receive any income yourself.

10) You were advised to update your application when you determined what the changes in your income would be for 2018.

11) Your application indicated you would not take any deductions on your 2018 tax return. You testified that you are currently paying off a student loan that you cosigned and you are not sure if you can deduct any portion of those payments. You were directed to consult a tax professional and update your application in the event you decided to take a deduction for student loan interest payments.

12) Your application indicates you reside in Kings County.

13) You testified that you cannot afford to pay the premiums for a qualified health plan with the amount of APTC you are currently eligible for, because you have various personal expenses for which you are responsible.

14) Additionally, you testified that you are currently paying off a large tax bill, so you do not have any additional money to pay the premiums for a health plan.

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 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 $16,250.00 for a two-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

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 $16,250.00 for a two-person household (82 Fed. Reg. 8831).

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 2018 FPL, which is $16,460.00 for a two-person household (83 Fed. Reg. 2642).

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 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*.).

Legal Analysis

The first issue under review is whether NYSOH properly determined you were eligible to receive up to $142.00 per month in APTC, effective January 1, 2018.

The updated application submitted on your behalf on December 15, 2017 listed your annual expected household income for 2018 as $47,316.00. Although you testified that your income situation has changes since you filed your application, you also testified that you were currently unsure of what your income would be in 2018. You were directed to update your application when you determined what the changes in your income would be for 2018. Thus, in the absence of any reliable evidence of your current income, this decision is based on the information attested to in your last application, which you testified was accurate at the time it was submitted on December 15, 2017.

It is noted that during the hearing, you testified you have various personal financial obligations that render paying the premium for a qualified health plan impossible. However, since eligibility for financial assistance through NYSOH is based on an individual's modified adjusted gross income as defined in the federal tax code, and 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 considered when NYSOH computes your modified adjusted gross income for APTC purposes. Thus, NYSOH properly based its eligibility determination on the $47,316.00 annual household income amount attested to in your application.

The evidence establishes that, at the time of your December 15, 2017 application, you were in a two-person household, because you intended to file your 2018 tax return with a tax filing status of married filing jointly and you would 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 $47,316.00 is 291.35% of the 2017 FPL for a two-person household. At 291.35% of the FPL, the expected contribution to the cost of the health insurance premium is 9.31% of income, or $367.00 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 ($367.00 per month), which equals $142.30 per month. Therefore, rounding to the nearest

dollar, NYSOH correctly determined you eligible for up to $142.00 per month in APTC, based on the information in your December 15, 2017 application.

The second issue is whether you were properly determined ineligible for cost-sharing reductions.

Cost-sharing reductions are available to applicants with a household income no greater than 250% of the FPL. Since a household income of $47,316.00 is 291.35% of the applicable FPL, over the 250% limit, NYSOH correctly found you to be 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 $16,240.00 for a two-person household. Since an annual household income of $47,316.00 is 291.35% of the 2017 FPL, over the 200% limit, NYSOH correctly found you ineligible for the Essential Plan.

The fourth issue is whether NYSOH properly determined 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 $16,460.00 for a two-person household. Since $47,316.00 is 287.46% of the 2018 FPL, over the 138% limit, NYSOH properly found you 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 testified, and your December 15, 2017 application indicates, that at the time of the application, your household income consisted of monthly Social Security benefits and pension payments your spouse received monthly in the amount of $2,197.00 and $1,746.00, respectively.

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 $1,893.00 per month. Since the evidence establishes that your household income for December 2017

was $3,943.00, over the $1,893.00 monthly income limit, you do not qualify for Medicaid based on monthly income as of the date of your application.

Since the December 16, 2017 eligibility determination notice properly stated that, based on the information in your application, you were eligible for up to $142.00 per month in APTC, ineligible for cost-sharing reductions, ineligible for the Essential Plan and ineligible for Medicaid, it is correct and is AFFIRMED.

However, it is noted that you have a duty to update your NYSOH account with any changes that may affect your eligibility, such as any changes in household size or income, within 30 days of such change.

Because you have reported that your [redacted], and you are no longer sure of your income for this year, this matter will be returned to NYSOH for further review.

Decision

The December 16, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: March 20, 2018

How this Decision Affects Your Eligibility

You remain eligible for up to $142.00 in APTC, and ineligible for cost-sharing reductions, the Essential Plan, and Medicaid, based on the information in your December 15, 2017 application.

However, because you have testified to changes in your circumstances, your case is being returned to NYSOH to assist you in updating your account.

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
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

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).

Summary

The December 16, 2017 eligibility determination notice is AFFIRMED.

You remain eligible for up to $142.00 in APTC, and ineligible for cost-sharing reductions, the Essential Plan, and Medicaid, based on the information in your December 15, 2017 application.

However, because you have testified to changes in your circumstances, your case is being returned to NYSOH to assist you in updating your account.

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 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).