



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

## Notice of Decision

Decision Date: April 23, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000028255

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

On April 5, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 27, 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 number 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.

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## Decision

Decision Date: April 23, 2018

NY State of Health Account ID: [REDACTED]  
Appeal Identification Number: AP000000028255

[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 that you were eligible to receive up to \$202.00 per month in advance payments of the premium tax credit (APTC)?

Did NYSOH properly determine that you were eligible for cost-sharing reductions (CSR)?

Did NYSOH properly determine that you were ineligible to enroll in the Essential Plan?

## Procedural History

On December 22, 2017, NYSOH issued two notices:

- (1) An eligibility determination notice stating, in relevant part, that you were eligible to enroll in the Essential Plan with a \$20.00 premium per month for a limited time, effective February 1, 2018. The notice instructed you to submit proof of income by March 21, 2018, to confirm your eligibility; and
- (2) An enrollment notice confirming that as of December 21, 2017, you were enrolled in an Essential Plan with an enrollment start date of February 1, 2018.

Also on December 22, 2017, you faxed additional income documentation to your NYSOH account (see Document [REDACTED]).

On December 26, 2017, your NYSOH account was updated.

On December 27, 2017, NYSOH issued an eligibility determination notice stating that you were eligible for up to \$202.00 per month in APTC and CSR, effective February 1, 2018. The notice further stated that you were no longer eligible for the Essential Plan because your income was above the income limit for the program.

Also on December 27, 2017, NYSOH issued a disenrollment notice stating that your Essential Plan coverage would end as of February 1, 2018, because you were no longer eligible to enroll in the Essential Plan.

On February 1, 2018, you spoke with NYSOH's Account Review Unit and requested an appeal insofar as the amount of financial assistance you were determined eligible to receive.

On March 30, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken and the record was fully developed during the hearing. The record was closed at the end of the hearing.

## **Findings of Fact**

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

- 1) According to your NYSOH account and testimony, you expect to file a 2018 federal income tax return with the tax status of Head of Household (with qualifying individual), and expect to claim your [REDACTED] child as a dependent on that tax return.
- 2) On December 22, 2017, you submitted two earnings statements from your employer, [REDACTED], to NYSOH. According to the statements, you were issued \$1,571.64 in gross pay on December 1, 2017 and \$1,402.42 on December 15, 2017 (see Document [REDACTED]).
- 3) You testified that the biweekly statements accurately represented your biweekly income.
- 4) You testified that you expect to take college classes in August 2018; however, you did not know how much the tuition and fees would be.
- 5) According to your NYSOH account, you reside in [REDACTED], New York.

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

## **Applicable Law and Regulations**

### 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 time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

Subject to income limitations, tuition and fees for higher education paid by the taxpayer to a qualified educational institution can be deducted from their gross income in an amount up to \$4,000.00. The allowable deduction does not apply to taxable years beginning after December 31, 2017 (26 USC § 222(b), (e)).

On February 9, 2018, the Bipartisan Budget Act of 2018 amended the Internal Revenue Code of 1986 to extend certain expiring provisions, including the Above the Line Deduction for Qualified Tuition and Related Expenses. The Qualified Tuition and Related Expense Deduction was extended through December 31, 2017 (H.R. 1892 - 115th Congress (2017-2018), Public Law No. 115-123).

### Household Composition

For APTC and CSR, the household size equals the number of individuals for whom the taxpayers are 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 (26 USC § 36B(d)(1)).

### Advance Payments of Premium Tax Credit

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

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exemption deduction for a person who meets the eligibility requirements to enroll in a QHP, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (see 45 CFR § 155.305(f), 42 CFR § 435.119(b), 42 CFR § 435.911(b)(1), 42 CFR § 435.603(d)(4)).

The maximum amount of APTC that can be authorized equals:

- 1) the cost of the health insurance premium for the taxpayer's coverage family in the second lowest cost silver plan offered through NY State of Health in the county where the taxpayer resides

*minus*

- 2) the taxpayer's expected contribution amount

(see 26 USC § 36B, 26 CFR § 1.36B-3).

The taxpayer's expected contribution amount is the amount that the taxpayer is expected to spend on health insurance premiums. The expected contribution for 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 \$16,240.00 for a two-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 (CSR) are available to a person who (1) is eligible to enroll in a QHP through NYSOH, (2) meets the requirements to receive APTC, (3) is expected to have an annual household income that does not exceed 250%

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of the FPL for the first day of the open enrollment period of the benefit year for which coverage is requested, and (4) is enrolled in a silver-level QHP (45 CFR § 155.300(a), 45 CFR § 155.305(g)(1)).

### Essential Plan

NYSOH must generally determine an applicant eligible for the Essential Plan, a basic health plan, if the person is (1) a resident of New York State, (2) expects to have a household income between 138% and 200% of the applicable federal poverty level (FPL) or, in the case of an individual who is a lawfully present non-citizen who is ineligible for Medicaid or Child Health Plus as a result of their immigration status, has a household income that is between 0% and 200% of the FPL, (3) is not otherwise eligible for minimum essential coverage except through the individual market, (4) is 64 years old or younger, (5) is a citizen or a lawfully present non-citizen, and (6) is not incarcerated (see 42 CFR § 600.305, 42 CFR § 435.603(d)(4), 45 CFR § 155.305(e), NY Social Services Law § 369-gg(3), 42 USC § 18051).

### Affordability Exemption

Under some circumstances, a person may receive an exemption from paying a penalty for not purchasing health insurance coverage. Such an exemption may be granted if that person can show that he or she experienced a financial hardship or has domestic circumstances that (1) caused an unexpected increase in essential expenses that prevented that person from obtaining health coverage under a QHP; (2) would have caused the person to experience serious deprivation of food, shelter, clothing, or other necessities, as a result of the expense of purchasing health coverage under a QHP; or (3) prevented that person from obtaining coverage under a QHP (45 CFR § 155.605(a), (g)).

NY State of Health has deferred to the U.S. Department of Health and Human Services (HHS) on the matter of hardship exemptions (see 45 CFR § 155.505(c)).

## **Legal Analysis**

The first issue under review is whether NYSOH properly determined that you were eligible for up to \$202.00 of APTC per month.

On December 22, 2017, you submitted your December 1, 2017 and December 15, 2018, biweekly earnings statements from your employer. The statements reflect that you were issued \$1,571.64 on December 1, 2017 and \$1,402.42 on December 15, 2017 (see Document [REDACTED]). Based on the documentation submitted, your expected household income was calculated to be  $((\$1,571.64 (+) \$1,402.42) \times 13 \text{ periods}) \$38,662.78$ .

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For an individual who expects to file a federal income tax return, the household equals the taxpayers and the number of individuals for whom the taxpayer is claiming as a dependent.

You attested that you expect to file a 2018 federal income tax return with the tax status of Head of Household (with qualifying individual), and expected to claim your [REDACTED] child as a dependent on that return. Therefore, you are in a two-person household for purposes of this analysis.

You reside in Monroe County, New York, where the second lowest cost silver plan available for an individual through NYSOH costs \$449.12 per month.

An annual income of \$38,663.00 is 238.07% of the 2017 FPL for a two-person household. At 238.07% of the 2017 FPL, the expected contribution is 7.68% of the household income, or \$247.44 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 (\$449.12 per month) minus your expected contribution (\$247.44 per month), which equals \$201.68 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to \$202.00 per month in APTC.

The second issue under review is whether you were properly found ineligible for CSR.

CSR are available to a person who has a household income no greater than 250% of the 2017 FPL. Since a two-person household with an income of \$38,663.00 is 238.07% of the 2017 FPL, NYSOH correctly found you to be eligible for CSR.

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

The Essential Plan is provided through NYSOH to individuals who meet the non-financial requirements and have a household modified adjusted gross income that is between 138% and 200% of the FPL for the applicable family size. Since an annual household income of \$38,663.00 is 238.07% of the 2017 FPL, NYSOH properly found you to be ineligible for the Essential Plan.

Therefore, the January 23, 2018 eligibility determination notice is AFFIRMED.

You testified that you expect to take college classes in August 2018; however, you did know how much the tuition and fees would be. As of the date of your hearing, the tuition and fees deduction has not been extended beyond the taxable year that ended on December 31, 2017. At the end of a tax year, a



person who elects to take the APTC to help pay for the cost of an insurance premium must file a tax return and reconcile any differences between the income reported to NYSOH and the income reflected on their federal income tax return. If you received less tax credit than you were entitled to, you may receive an income tax refund.

## **Decision**

The December 27, 2017 eligibility determination notice is AFFIRMED.

**Effective Date of this Decision:** April 23, 2018

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

This decision does not change your eligibility for or enrollment in health insurance coverage through NYSOH.

## **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

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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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

### **Summary**

The December 27, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility for or enrollment in health insurance coverage through NYSOH.

### **Legal Authority**

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

**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)**

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### **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 sre wo, fre 1-855-355-5777. ye&etumi 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.

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