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

Notice of Decision

Decision Date: May 31, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000015866

[redacted]

Dear [redacted]

On May 23, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's February 7, 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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Decision Date: May 31, 2017

NY State of Health Account ID: [redacted]
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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 your spouse and child were eligible to receive up to $278.00 per month in advance payments of the premium tax credit (APTC), as of February 7, 2017?
>
> Did NYSOH properly determine that your spouse and child were not eligible for cost-sharing reductions (CSR), as of February 7, 2017?

Procedural History

On December 7, 2016, NYSOH issued an eligibility determination stating that your spouse and child were eligible for up to $426.00 monthly of APTC and CSR for a limited time, effective as of January 1, 2017. The notice also directed you to provide additional proof of income by March 6, 2017, to confirm your spouse and child's eligibility for financial assistance.

Also on December 7, 2016, NYSOH issued a plan enrollment notice confirming that your spouse and child were enrolled in a qualified health plan with a monthly premium of $735.63 after APTC was applied and an enrollment start date of January 1, 2017.

On December 13, 2016, additional income documentation was uploaded to your NYSOH account (*see* Document [redacted]).

On December 30, 2016, your NYSOH account was updated.

On December 31, 2016, NYSOH issued an eligibility determination notice stating that your spouse and child were eligible for Medicaid effective as of December 1, 2016.

Also on December 31, 2016, NYSOH issued a disenrollment notice stating that your spouse and child's QHP would end on January 1, 2017, because they were no longer eligible to enroll in a QHP.

On January 10, 2017, NYSOH issued a plan enrollment notice confirming that, as of January 9, 2017, your spouse and child were enrolled in a Medicaid Managed Care (MMC) plan with an enrollment start date of February 1, 2017.

On February 6, 2017, your NYSOH account was updated.

On February 7, 2017, NYSOH issued three notices:

(1) A disenrollment notice stating that your spouse and child's MMC coverage would end on February 28, 2017 because they were no longer eligible to enroll in that plan;
(2) An eligibility determination notice stating that your spouse and child were eligible to receive up to $278.00 monthly of APTC for a limited time, effective as of March 1, 2017. The notice directed you to provide additional proof of income by May 7, 2017, to confirm their eligibility for financial assistance; and,
(3) A plan enrollment notice confirming that your spouse and child were enrolled in a QHP, with a monthly premium of $883.63 and an enrollment start date of March 1, 2017.

On February 15, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance your spouse and child were determined eligible to receive.

On May 23, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and closed at the end of the proceeding.

Findings of Fact

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

1) According to your NYSOH account and testimony, you are applying for health insurance for your spouse and child.

2) According to your NYSOH account and testimony, you expect to file your 2017 federal income tax return, with the tax status of married filing jointly, and expect to claim your child as a dependent on that return.

3) On December 13, 2016, your 2015 Form 1040 U.S. Individual Income Tax Return was uploaded to your NYSOH account. The return states that your adjusted gross income was $61,125.00 in 2015.

4) According to your February 6, 2017 application, you attested to a 2017 expected annual household income of $61,035.96.

5) You testified that you expect your 2017 adjusted gross income to be similar to your 2015 adjusted gross income.

6) According to your NYSOH account, your family resides in Nassau County, New York.

7) You testified that you are seeking more APTC for your spouse and child's coverage.

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)).

Household Composition

For purposes of advance premium tax credit (APTC) and cost-sharing reductions (CSR), 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 (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 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 2017 is set by federal law at 2.04% to 9.69% of household income (26 USC § 36B(b)(3)(A), 26 CFR § 1.36B-3T(g)(1), IRS Rev. Proc.2016-24).

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 2016 FPL, which is $20,160.00 for a three-person household (81 Fed. Reg. 4036).

For annual household income in the range of at least 300% but less than 400% of the 2016 FPL, the expected contribution in 2017 is 9.69% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

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% 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)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that your spouse and child were eligible for APTC of up to $278.00 per month.

The application that was submitted on February 6, 2017 listed an annual household income of $61,035.96, and the eligibility determination relied upon that information.

When calculating family size for APTC and CSR, a household size consists of the taxpayer, his or her spouse, and any claimed dependents. You testified that you expect to file your 2017 tax return, jointly with your spouse, and expect to claim your child as a dependent on that return. Therefore, your spouse and child are in a three-person household for purposes of this analysis.

Your family resides in Nassau County, where the second lowest cost silver plan available for a primary subscriber and one dependent through NYSOH costs $771.06 per month.

An annual income of $61,035.96 is 302.76% of the 2016 FPL for a three-person household. At 302.76% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 9.69% of income, or $492.87 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 a primary subscriber and one dependent in your county ($771.06 per month) minus your expected contribution ($492.87 per month), which equals $278.19 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $278.00 per month in APTC.

The second issue under review is whether your spouse and child were properly found 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 $61,035.96 is 302.76% of the applicable FPL, NYSOH correctly found your spouse and child to be ineligible for cost sharing reductions.

You submitted your 2015 Form 1040 U.S. Individual Income Tax Return to NYSOH (*see* Document [redacted]). The return states that your adjusted gross income was $61,125.00 in 2015. Furthermore, you testified that you expect your 2017 adjusted gross income to be similar to your 2015 adjusted gross income. The record reflects that that the annual household income provided in your 2015 federal income tax return is not materially different than the household income attested to in your February 6, 2017 application. Therefore, your case will not be returned to NYSOH to redetermine your spouse and child's eligibility for financial assistance. Any adjustments to the amount of APTC to which your spouse and child were titled to share in during 2017 can be reconciled at the time you file your 2017 federal tax return.

Therefore, the February 7, 2017, eligibility determination notice correctly stated that your spouse and child eligible for up to $278.00 of APTC and ineligible for cost-sharing reductions, and is AFFIRMED.

Decision

The February 7, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: May 31, 2017

How this Decision Affects Your Eligibility

Your spouse and child remain eligible for up to $278.00 per month in APTC.

Your spouse and child remain ineligible for cost-sharing reductions.

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 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 February 7, 2017 eligibility determination notice is AFFIRMED.

Your spouse and child remain eligible for up to $278.00 per month in APTC.

Your spouse and child remain ineligible for cost-sharing reductions.

Legal Authority

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

A Copy of this Decision Has Been Provided To:

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.

□□□□□ (Bengali)

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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 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)

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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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