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

Notice of Decision

Decision Date: August 16, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000018624

[redacted]

Dear [redacted],

On August 10, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's April 19, 2017 and June 28, 2017 eligibility determination notices.

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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DEPARTMENT OF HEALTH
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Albany, NY 12211

Decision

Decision Date: August 16, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000018624

[redacted]

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 $248.00 per month in advance payments of the premium tax credit, effective June 1, 2017?
>
> Did NY State of Health properly determine that you and your child, [redacted] were eligible to receive up to $529.00 per month in advance payments of the premium tax credit, effective August 1, 2017?

Procedural History

On April 18, 2017, you submitted an application for financial assistance.

On April 19, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive an advance premium tax credit (ATPC) of up to $248.00 per month, and if you selected a silver-level health plan, eligible for cost-sharing reductions (CSR), effective June 1, 2017. The notice also stated that your child was no longer eligible for Medicaid; however, her Medicaid coverage would continue until June 30, 2017 according to the Medicaid continuous coverage guidelines. The eligibility determination for your child was effective April 1, 2017.

On May 2, 2017, you spoke to NYSOH's Account Review Unit and appealed insofar as you were found eligible for an APTC no greater than $248.00 per month.

On May 16, 2017, NYSOH received an update to your application for health insurance.

On May 17, 2017, NYSOH issued a notice of eligibility determination stating that you were eligible to receive an ATPC of up to $248.00 per month, and if you selected a silver-level health plan, eligible for CSR, effective July 1, 2017. The notice also stated that your child was eligible for Child Health Plus (CHP) with a $9.00 monthly premium, effective July 1, 2017.

Also on May 17, 2017, NYSOH issued a disenrollment notice confirming that your child's Medicaid coverage would end effective June 30, 2017.

Finally, on May 17, 2017, NYSOH issued an enrollment notice confirming your selection of a CHP plan for your child's coverage on May 16, 2017. The notice stated that her CHP coverage would begin effective July 1, 2017, with a $9.00 monthly premium. The notice also advised you to select a QHP.

On June 19, 2017, NYSOH received an update to your application for health insurance.

On June 20, 2017, NYSOH issued an eligibility determination notice based on the information contained in the June 19, 2017 application. The notice stated that you and your child were eligible for an APTC of up to $556.00 per month and, if you selected a silver-level plan, eligible for CSR, effective August 1, 2017.

Also on June 20, 2017, NYSOH issued a disenrollment notice confirming that your child's coverage through CHP would end on July 31, 2017 because this plan was only available to individuals who are 18 years of age or younger.

Finally, on June 20, 2017, NYSOH issued an enrollment notice confirming your selection of a bronze-level QHP for the coverage of you and your child, beginning June 1, 2017, with a monthly premium of $593.55 after giving effect to the $556.00 APTC.

On June 27, 2017, NYSOH received an update to your application for health insurance.

On June 28, 2017, NYSOH issued an eligibility determination notice based on the information contained in the June 27, 2017 application. The notice stated that you and your child were eligible for an APTC of up to $529.00 per month and, if you selected a silver-level plan, eligible for CSR, effective August 1, 2017.

Also on June 28, 2017 issued an enrollment notice confirming your selection of a bronze-level QHP for the coverage of you and your child, beginning June 1,

2017, with a monthly premium of $593.55 after giving effect to the $529.00 APTC. The notice also stated that your APTC would begin effective July 1, 2017.

On August 10, 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 hearing.

Findings of Fact

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

1) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You will claim your child as your sole dependent on that tax return.

2) You are seeking insurance for yourself and your child.

3) Your child turned [redacted] old on [redacted]

4) The April 18, 2017 application listed annual household income of $33,800.00, which consisted solely of the $650.00 gross weekly income you received from your employment with [redacted]. You testified that this amount was a reasonably accurate estimate of your earnings at the time.

5) You further revised your application on June 27, 2017, which listed an annual household income of $36,000.00, which included only the increased income you anticipated receiving from your employment during 2017.

6) You testified that you were seeking a review of not only your eligibility of APTC based on your April 18, 2017 application, but also the eligibility of you and your child for APTC based on the revised application you submitted on June 27, 2017.

7) You testified, and each of your applications reflect, that you will not be taking any deductions on your 2017 tax return.

8) You live 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

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 $16,020.00 for a two-person household (81 Federal Register 4036).

For annual household income in the range of at least 200% but less than 250% of the 2016 FPL, the expected contribution is between 6.43% and 8.21% of the household income (26 CFR § 1.36B-3T(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2016-24).

Upon making an eligibility redetermination, NYSOH must notify the applicant and implement any changes in eligibility to APTC effective as of the first day of the month following the date of the notice (45 § 155.310(f), 45 CFR § 155.330(e), (f)(1)(i)).

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)).

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)).

Legal Analysis

The first issue is whether NYSOH properly determined that you were eligible for an APTC of up to $248.00 per month, effective June 1, 2017.

The application that was submitted on April 18, 2017 listed an annual household income of $33,800.00, and the eligibility determination relied upon that information.

You are in a two-person household. You expect to file your 2017 income taxes as head of household and will claim your child as your sole dependent on that tax return.

You reside in Schenectady County, where the second lowest cost silver plan available for an individual through NYSOH costs $440.36 per month.

An annual income of $33,800.00 is 210.97% of the 2016 FPL for a two-person household. At 210.97% of the FPL, the expected contribution to the cost of the health insurance premium is 6.82% of income, or $192.13 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 ($440.36 per month) minus your expected contribution ($192.13 per month), which equals $248.23 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $248.00 per month in APTC, effective June 1, 2017.

Therefore, the April 19, 2017 eligibility determination notice is AFFIRMED.

The second issue is whether NYSOH properly determined that you and your child were eligible for an APTC of up to $529.00 per month, effective August 1, 2017.

The application that was submitted on April 18, 2017 listed an annual household income of $36,000.00, which was comprised of only the income you anticipated receiving from your employment, but did not include the $80.00 per week your child received from her employment with [redacted] and the eligibility determination relied upon that information. Again, the eligibility determination relied upon that information.

An annual income of $36,000.00 is 210.97% of the 2016 FPL for a two-person household. At 224.72% of the FPL, the expected contribution to the cost of the health insurance premium is 7.31% of income, or $219.30 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 ($748.61 per month) minus your expected contribution ($219.30 per month), which equals $529.31 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $529.00 per month in APTC, effective July 1, 2017.

Therefore, the June 28, 2017 eligibility determination notice is MODIFIED to stated that you and your child's eligibility for an APTC of $529.00 per month should have begun effective July 1, 2017, but is otherwise affirmed.

Decision

The April 19, 2017 eligibility determination notice is AFFIRMED.

The June 28, 2017 eligibility determination notice is MODIFIED to stated that you and your child's eligibility for an APTC of $529.00 per month should have begun effective July 1, 2017, but is otherwise affirmed.

Effective Date of this Decision: August 16, 2017

How this Decision Affects Your Eligibility

You were eligible for an APTC of up to $248.00 per month and, if you selected a silver-level plan, eligible for CSR, effective June 1, 2017.

You and your child were eligible for an APTC of up to $529.00 per month and, if you selected a silver-level plan, eligible for CSR, effective July 1, 2017.

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

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).

- By mail at:

  NY State of Health Appeals
  P.O. Box 11729
  Albany, NY 12211

- By fax: 1-855-900-5557

Summary

The April 19, 2017 eligibility determination notice is AFFIRMED.

The June 28, 2017 eligibility determination notice is MODIFIED to stated that you and your child's eligibility for an APTC of $529.00 per month should have begun effective July 1, 2017, but is otherwise affirmed.

You were eligible for an APTC of up to $248.00 per month and, if you selected a silver-level plan, eligible for CSR, effective June 1, 2017.

You and your child were eligible for an APTC of up to $529.00 per month and, if you selected a silver-level plan, eligible for CSR, effective July 1, 2017.

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).