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

Notice of Decision

Decision Date: October 19, 2017

NY State of Health Account ID [redacted]
Appeal Identification Number: AP000000020149

[redacted]

Dear [redacted],

On September 27, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's June 3, 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.

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

Decision

Decision Date: October 19, 2017

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000020149

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 and your spouse were eligible to receive up to $347.00 per month in advance payments of the premium tax credit (APTC) as of June 3, 2017?
>
> Did NYSOH properly determine your child eligible was eligible to enroll in Child Health Plus with a premium of $30.00 per month, effective as of July 1, 2017?

Procedural History

On May 3, 2017, your account was systemically updated.

On May 4, 2017, NYSOH issued an eligibility determination notice stating, in relevant part, that your child qualified for health care coverage under Child Health Plus at a cost of $30.00 per month, effective July 1, 2017.

On May 17, 2017, NYSOH issued a plan enrollment notice confirming, in relevant part, that your child was enrolled in a Child Health Plus plan on May 16, 2017, with an enrollment start date of July 1, 2017.

On June 2, 2017, you updated your account.

On June 3, 2017, NYSOH issued an eligibility determination notice stating that you and your spouse were eligible for up to $347.00 monthly of APTC, effective

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July 1, 2017. The notice also stated that your child was eligible for Child Health Plus, with a monthly premium of $30.00, effective as of July 1, 2017.

Also on June 3, 2017, NYSOH issued a plan enrollment notice confirming that as of June 2, 2017, you and your spouse were enrolled in a QHP and your child was enrolled in a Child Health Plus plan, with plan enrollment start dates of July 1, 2017.

Also on June 30, 2017, you spoke to NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance you, your spouse, and child were determined eligible to receive.

On September 27, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken during the hearing, and the record was left open until October 14, 2017, to allow you to submit additional income documentation to NYSOH Appeals Unit.

On October 11, 2017, you submitted six-pages of documentation to NYSOH Appeals Unit. That documentation was made part of the record as "Appellant's Exhibit A." The record is now complete and closed.

Findings of Fact

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

1) You testified that you are only appealing the amount of financial assistance that you, your spouse, and child were eligible to receive.

2) According to your NYSOH account, your child was born on [redacted]

3) According to your NYSOH account and testimony, you expect to file a 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.

4) According to your June 2, 2017 application, you attested to an annual household income $71,402.01. You attested that:

   (a) You were issued $1,477.00 biweekly from [redacted];
   (b) Your spouse was issued $500.00 every week; and
   (c) Your child was employed at [redacted] with an expected yearly income of $7,000.00.

5) You testified that the income information in the June 2, 2017, application may no longer represent your household's expected household income.

6) You submitted your last two biweekly earnings statements from your employer, [redacted]. You were issued:

   (a) $1,557.60 on September 22, 2017;
   (b) $1,486.98 on October 6, 2017;

   (*see* Appellant's Exhibit A, pp. 2-3).

7) You submitted a signed letter from your spouse stating that they are a [redacted] and make on average $350.00 to $500.00 per week, depending on the work available (*see* Appellant's Exhibit A, p. 4).

8) You testified that your child was employed at [redacted]; however, their last day of employment was on June 23, 2017.

9) You submitted a weekly earnings statement from your child's employer. Your child was issued $24.25 in gross pay on June 23, 2017, with a year-to-date gross income of $3,767.30 (see Appellant's Exhibit A, p. 6).

10) According to your NYSOH account, your family resides in [redacted] [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 finds from time savings accounts, deductions attributable to royalties, and certain retirement savings (26 USC § 62(a)).

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The MAGI-based income of a child who is not required to file a tax return is not included in household income (42 CFR § 435.603(d)(2)).

A person is not required to file a tax return if their gross income is less than the sum of the exemption amount plus the basic standard deduction allowable for that person (26 USC § 6012(a)(1)(A)(i)). For the 2016 year, a dependent who had yearly gross earned income greater than $6,300.00 or gross unearned income greater than $1,050.00 would be required to file a tax return (see IRS Publication 929 (2016)).

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 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 Federal Register 4036).

For annual household income in the range of at least 300% but less than 400% of the 2016 FPL, the expected contribution is between 9.69% and 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).

Child Health Plus - Eligibility

A child who meets the eligibility requirements for CHP may be eligible to receive a subsidy payment if the child resides in a household with a household income at or below 400% of the federal poverty level (FPL) (NY PHL § 2511(2)(a)(iii)).

The amount of the premium payment, if any, that must be made on behalf of a child who enrolls in a CHP plan depends upon the child's family household income (NY PHL § 2510(9)(d)). No payments are required for eligible children whose family household income is less than 160% of the FPL (NY PHL § 2510(9)(d)(1)). If the family household income is 160% or higher, premiums range from $9.00 per month to $60.00 per month (NY PHL § 2510(9)(d)).

In an analysis of Child Health Plus 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 2017 FPL, which was $20,420.00 for a three-person household (82 Fed. Reg. 8831).

Child Health Plus - Renewal

"A State must specify a method for determining the effective date of eligibility for [Child Health Plus], which can be determined based on the date of application or through any other reasonable method that ensures coordinated transition of children between [Child Health Plus] and other insurance affordability programs as family circumstances change and avoids gaps or overlaps in coverage," including for periodic renewals (42 CFR § 457.340(f); 42 CFR §457.343).

The eligibility of children enrolled in Child Health Plus whose financial eligibility is determined using MAGI-based income must be renewed once every 12 months, and no more frequently than once every 12 months (42 CFR § 457.343; 42 CFR § 435.916(a)(1), (d)).

Legal Analysis

The first issue under review is whether NYSOH properly determined that you and your spouse were eligible for up to $347.00 of APTC per month.

In your June 2, 2017 application, you attested to an expected annual household income of $71,402.01, and the June 3, 2017 eligibility determination relied upon that information.

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 2017 federal income tax return with the tax status of married filing jointly, and expected to claim one dependent on that tax return. Therefore, you were in a three-person household.

You reside in Rockland County, New York, where the second lowest cost silver plan available for a couple through NYSOH costs $922.98 per month.

An annual income of $71,402.01 is 354.18% of the 2016 FPL, for a three-person household. At 354.18% of the FPL, the expected contribution is 9.69% of the household income, or $576.57 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 ($922.98 per month) minus your expected contribution ($576.57 per month), which equals $346.41 per month. Therefore, rounding up to the nearest dollar, NYSOH correctly determined you and your spouse to be eligible for up to $347.00 per month in APTC.

The second issue under review is whether NYSOH properly determined that your child was eligible to enroll in Child Health Plus with a monthly premium of $30.00.

On May 4, 2017, NYSOH issued a notice stating that your child was eligible for Child Health Plus and enrolled in a Child Health Plus plan, with a monthly premium of $30.00, effective July 1, 2017.

Generally, a child’s eligibility for financial assistance toward their Child Health Plus health insurance premiums is determined once every twelve months. This

twelve-month period is based on the effective date of their coverage. Therefore, your child remained eligible to enroll in Child Health Plus, with a $30.00 monthly premium.

Therefore, the June 3, 2017 eligibility determination notice stating that you and your spouse were eligible for up to $347.00 per month in APTC, and your child was eligible for Child Health Plus with a $30.00 monthly premium, effective July 1, 2017, is AFFIRMED.

You testified that the income information in the June 2, 2017 application may no longer represent your household's expected household income. You were instructed to provide additional income documentation so that your 2017 household income may be accurately computed.

You submitted your last two biweekly earnings statements from your employer. You were issued $1,557.60 on September 22, 2017, and $1,486.98 on October 6, 2017, consisting of four weeks' pay. Therefore, your expected 2017 income is $39,579.54 (($1,557.60 + $1,486.98) X 13 (52 weeks/4).

In your June 2, 2017, application you attested that your spouse was consistently issued $500.00 per week. However, you submitted a signed letter from your spouse stating that they were a [redacted] and make on average between $350.00 to $500.00 per week. Therefore, your spouse's average weekly income is $425.00. Based on the available information, your spouse's expected 2017 income is $22,100.00 ($425.00 X 52 weeks).

In your June 2, 2017, application you attested that your child was employed at [redacted] with an expected yearly income of $7,000.00. However, you testified that your child was employed at [redacted], and their last day of employment was on June 23, 2017. Further, you submitted your child's June 23, 2017, weekly paystubs stating that their year-to-date gross income was $3,767.30.

A child or a dependent's income is included in the household's MAGI if the child is required to file a tax return. A dependent will be required to file a tax return if their earned income is greater than $6,300.00. According to the available information, your child has an expected 2017 income of $3,767.30. Therefore, your child's income should not be included in your household's expected annual income.

Based on the available evidence, your case is RETURNED to NYSOH to recalculate your household's eligibility for financial assistance based on a three-person household, for a family living in Rockland County, New York, with an expected income of $61,679.54 ($39,579.54 + $22,100.00).

Decision

The June 3, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your household's eligibility for financial assistance based on a three-person household, for a family living in Rockland County, New York, with an expected income of $61,679.54, and to notify you of its redetermination.

Effective Date of this Decision: October 19, 2017

How this Decision Affects Your Eligibility

You and your spouse were properly determined eligible for up to $347.00 monthly in APTC.

Your child was properly determined eligible for Child Health Plus with a $30.00 monthly premium.

However, based on a more accurate representation of your household income, your case is being sent back to NYSOH to redetermine your household's eligibility for financial assistance. NYSOH will notify you of its redetermination.

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 June 3, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your household's eligibility for financial assistance based on a three-person household, for a family living in Rockland County, New York with an expected income of $61,679.54, and to notify you of its redetermination.

You and your spouse were properly determined eligible for up to $347.00 monthly in APTC.

Your child was properly determined eligible for Child Health Plus with a $30.00 monthly premium.

However, based on a more accurate representation of your household income, your case is being sent back to NYSOH to redetermine your household's eligibility for financial assistance. NYSOH will notify you of its redetermination.

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Legal Authority

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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।

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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 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.

(Urdu)اردو

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.

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