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

Notice of Decision

Decision Date: January 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021485

[redacted]

[redacted]

On December 12, 2017, you appeared by telephone at a hearing on your appeal of NY State of Health's August 10, 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.

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).

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

Decision

Decision Date: January 9, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000021485

[redacted]

Issues

The issues presented for review by the Appeals Unit of NY State of Health are:

Did NY State of Health (NYSOH) properly calculate your household's modified adjusted gross income that was used in determining your eligibility for financial assistance?

Did NYSOH properly determine that you were eligible for an advance payment of the premium tax credit of up to $184.00 per month?

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

Did NYSOH properly determine that you were not eligible for the Essential Plan?

Procedural History

On August 10, 2017, NYSOH issued an eligibility determination notice, based on your August 9, 2017 updated application, stating that you were eligible to receive an advance payment of the premium tax credit (APTC) of up to $184.00 per month and eligible for cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective September 1, 2017. That notice further stated that you were not eligible for the Essential Plan as of August 31, 2017.

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).

On August 15, 2017, you contacted NYSOH's Account Review Unit and requested an appeal of that eligibility determination insofar as you were not eligible for additional financial assistance.

On December 12, 2017, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was developed during the hearing and held open to December 27, 2017 to allow you to submit supporting documents.

As of December 27, 2017, the Appeals Unit did not receive any documents from you and none were viewable in your NYSOH account. Therefore, the record was closed that same day and this decision is based on the record as developed at the time of the hearing.

Findings of Fact

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

1) You are seeking additional financial assistance for yourself.

2) You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You further testified that, although your application stated you will claim two dependents on your tax return, you will claim three dependents on that tax return, including your two children and your brother.

3) The application that was submitted on August 9, 2017, listed annual household income of $45,150.00, consisting of $45,000.00 you receive in employment income and $150.00 your oldest child receives in weekly income from his employment.

4) You testified that your income at the time of your application was correct, but that NYSOH incorrectly counted your oldest child's income when calculating your household income. You testified he is a full-time high school student and does not work every week, but has employment income of approximately $150.00 per week before taxes.

5) You testified that you, your children, and your brother have no other sources of income.

6) According to your NYSOH account, NYSOH utilized the gross household income amount of $45,000.00 in determining your eligibility in your August 9, 2017 application.

7) Your August 9, 2017 application states that your income for August 2017 is the same as your average monthly income. You testified this is correct.

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).

8) You testified that you will be taking a $1,452.00 pre-tax transit deduction in 2017.

9) According to your NYSOH account and your testimony, you live in Kings County, New York.

10) According to your NYSOH account, you did not enroll in a qualified health plan after you were determined eligible for monthly APTC.

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

Applicable Law and Regulations

Pre-Tax Transit Deduction

"Gross income" is all the income of the taxpayer from whatever source derived, including but not limited to compensation for services, gross income derived from business, interest, rents, dividends, pensions, and alimony, unless excluded by law (26 USC § 61). Subject to some limitations, certain fringe benefit deductions from an individual's income that are attributable to a Pre-Tax Transit could be excluded from a taxpayer's gross income (26 USC § 132 (5).

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)).

With regard to eligibility for financial assistance through NYSOH, a tax filer's household income includes the MAGI of all the individual's in the taxpayer's household who are required to file a federal tax return for the taxable year (26 CFR § 1.46B-1(e)(1); 42 CFR § 435.603(d)(1)). 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)).

The IRS determines whether a dependent is required to file an income tax return based on the amount of the dependent's earned and unearned income, marital status, age and whether that dependent is blind. According to the latest final publication, in cases where the dependent is under the age of 65, not blind and earns an income $6,300.00 or higher during the 2016 income tax year (or unearned income in the amount of $1,050 or higher), that dependent is required to file an income tax return for 2016 (IRS Pub. 929)

However, according to the IRS 2017 draft 1040 instructions, a dependent is under the age of 65, not blind and earns an income $6,350.00 or higher during the 2017 income tax year (or unearned income in the amount of $1,050 or higher) (IRS 2017 1040 instructions Chart B—For Children and Other Dependents).

Unearned income is generally all income other than salaries, wages and other amounts received as pay for work actually performed, including the taxable part of Social Security and pension payments (IRS Pub. 929).

For the purposes of determining a person's eligibility for financial assistance for health insurance through NYSOH, the term "MAGI" 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)).

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 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).

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)).

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).

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

The Essential Plan is considered minimum essential coverage therefore, a person who is eligible for the Essential Plan is not eligible for any premium tax credit because they are eligible for minimum essential coverage through the individual market (*see* 26 CFR § 1.36B-2(c)(1), 26 USC § 5000A(f)(1)(C)).

Legal Analysis

The first issue under review is whether NYSOH properly calculated your household's modified adjusted gross income that was used in determining your eligibility for financial assistance.

The application that was submitted on August 9, 2017 listed annual household income of $45,150.00, consisting of $45,000.00 you receive in employment income and $150.00 your oldest child receives in income from his employment. As such, your modified adjusted gross income for 2017 was calculated to be $45,000.00, and the eligibility determination relied upon that information.

Household income for the purposes of calculating a person's eligibility for financial assistance to help pay for the costs of health insurance through NYSOH, consists of the modified adjusted gross income of all tax filers in a household who are required to file a tax return. You testified that your income at the time of your application was correct, but that NYSOH incorrectly counted your child's income in your eligibility determination because he is a full-time high school student and does not work every week.

According to the most recent IRS final publication, a dependent is required to file a tax return when their earned income is greater than $6,300.00. Notwithstanding that you testified that your child has an income of $150.00 per week before taxes which may require him to file a tax return and have his income be included in your household's income in your application, you attested in your application that your child had annual income of $150.00. At an attested income of $150.00, NYSOH properly excluded your child's income in your household's income, based on the information you provided.

You further testified that you will be taking a $1,452.00 pre-tax transit deduction in 2017. Because the Internal Revenue Service rules exclude non-taxable expenses such as your Transit Pre-tax expense from your gross income, it can be excluded from your income in determining your gross household income. You failed to submit to NYSOH's Appeals Unit any documentation to prove the amount of this deduction. As such, the record lacks supporting documentary evidence as to a claimed pre-tax transit deduction and your testimony will not be considered.

Therefore, NYSOH properly determined your household income to be $45,000.00, based on the income information you provided in your application.

The second issue under review is whether NYSOH properly determined that you were eligible for an advance payment of the premium tax credit of up to $184.00 per month.

As stated above, your income is $45,000.00, as attested to in your application.

You testified that you expect to file your 2017 taxes with a tax filing status of head of household. You further testified that, although your application stated you will claim two dependents on your tax return, you will claim three dependents on that tax return, including your two children and your brother. However, you failed to provide any further evidence documenting this third dependent. Therefore, for purposes of the following analysis, you are in a three-person household.

You reside in Kings County, where the second lowest cost silver plan available for an individual through NYSOH costs $456.46 per month.

An annual income of $45,000.00 is 223.21% of the 2016 FPL for a three-person household. At 223.21% of the FPL, the expected contribution to the cost of the health insurance premium in 2017 is 7.26% of income, or $272.25 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 ($456.46 per month) minus your expected contribution ($272.25 per month), which equals $184.21 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $184.00 per month in APTC, based on the information you attested to you in your application.

The second issue under review is whether you 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 $45,000.00 is 223.21% of the applicable FPL, NYSOH correctly found you to be eligible for cost sharing reductions, based on the information you attested to you in your application.

The third issue under review is whether NYSOH properly determined that you were not eligible 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. On the date of your application, the relevant FPL was $20,160.00 for a three-person household. Since an annual household income of $45,000.00 is 223.21% of the

2016 FPL, NYSOH properly found you to be ineligible for the Essential Plan, based on the information you attested to you in your application.

Since the August 10, 2017 eligibility determination notice properly stated that, based on the information you provided, you were eligible for APTC of up to $184.00 per month, eligible for cost-sharing reductions, and not eligible for the Essential Plan, it is correct and is AFFIRMED.

Lastly, you testified that your gross household income, based on possibly including your oldest child's income, could be higher in 2017. You also testified that the number of your dependents would be greater. Please note that you are obligated to update your NYSOH account within 30 days of any changes to your household size or income.

Decision

The August 10, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: January 9, 2018

How this Decision Affects Your Eligibility

This decision does not change your eligibility.

You were properly determined eligible for up to $184.00 in APTC in 2017.

You were properly determined eligible for cost-sharing reductions in 2017.

You were properly determined ineligible for the Essential Plan.

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 August 10, 2017 eligibility determination notice is AFFIRMED.

This decision does not change your eligibility.

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).

You were properly determined eligible for up to $184.00 in APTC in 2017.

You were properly determined eligible for cost-sharing reductions in 2017.

You were properly determined ineligible for the Essential Plan.

Legal Authority

We are sending you this notice in accordance with 45 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).

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.

☒☒☒ (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.

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).

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।

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)

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).

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).