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

Notice of Decision

Decision Date: February 20, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025474

[redacted]

[redacted],

On February 13, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's November 23, 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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DEPARTMENT OF HEALTH
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Decision

Decision Date: February 20, 2018

NY State of Health Account ID: [redacted]
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[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 ineligible to receive advance payments of the premium tax credit, effective January 1, 2018?
>
> Did NY State of Health properly determine that you were ineligible for cost-sharing reductions?

Procedural History

On November 21, 2017, you applied for health insurance and financial assistance through NY State of Health (NYSOH).

Also on November 21, 2017, you uploaded income documentation to your NYSOH account.

November 22, 2017, NYSOH issued a notice of eligibility determination, based on the November 21, 2017 application, stating that you were eligible to receive up to $254.00 per month in advance payments of the premium tax credit (APTC) for a limited time, effective January 1, 2018. This notice directed you to produce proof of your household income by February 19, 2018.

On November 22, 2017, NYSOH reviewed the income documentation you submitted, recalculated your household income based on this documentation,

updated the income information in your application, and submitted an updated application on your behalf.

On November 23, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to purchase a qualified health plan at full cost through NYSOH, effective January 1, 2018. That notice also stated that you were not eligible for APTC or cost-sharing reductions because your annual household income was over the allowable income limits for those programs.

On December 7, 2017, you spoke to NYSOH's Account Review Unit and appealed that eligibility determination notice insofar as you were not eligible for APTC.

On December 20, 2017, NYSOH issued a notice stating that you were eligible for APTC for a limited time, effective January 1, 2018. This was because you had been granted Aid to Continue pending the outcome of your appeal.

On December 21, 2017, NYSOH issued an enrollment confirmation notice stating that you were enrolled in a qualified health plan with a plan enrollment start date of January 1, 2018 and that $126.00 per month in APTC would be applied to your monthly premium as of January 1, 2018.

On February 13, 2018, 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 tax return for 2018 with a tax filing status of single. You will not claim any dependents on that tax return.

2) You are seeking insurance for yourself.

3) The application that was submitted on November 21, 2017 listed annual household income of $33,948.00, consisting of $33,948.00 you earn from your self-employment, $1.00 in taxable interest, and $709.00 in ordinary dividends, less deductions of $4,200.00 for the deductible part of the self-employment tax and $1,010.00 for the self-employment health insurance deduction.

4) On November 21, 2017, you uploaded a letter dated August 2, 2017 signed by yourself which indicates that you are self-employed and work as an [redacted] as well as your 2016 1040. Your 2016 1040

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lists business income of $59,446.00, $1.00 in taxable interest, $709.00 in ordinary dividends, and $466.00 in qualified dividends, as well as self-employment tax deductions of $4,200.00 and self-employed health insurance deductions of $1,010.00.

5) On November 22, 2017, NYSOH reviewed the income documentation you submitted and calculated your annual income to be $57,480.00. That day, NYSOH submitted an application on your behalf.

6) The application that was submitted on November 22, 2017 listed annual household income of $57,480.00, consisting of $61,980.00 you earn from your self-employment, $1.00 in taxable interest, and $709.00 in ordinary dividends, less deductions of $4,200.00 for the deductible part of the self-employment tax and $1,010.00 for the self-employment health insurance deduction.

7) You testified that you had slightly more than $59,446.00 in self-employment earnings for 2017 and anticipate an increase in self-employment earnings for 2018, however, you are not yet sure regarding any increase for 2018.

8) You testified that you will receive approximately $1.00 in taxable interest in 2018, approximately $709.00 in ordinary dividends and $466.00 in qualified dividends in 2018.

9) You testified that you anticipate claiming approximately $4,200.00 in deductions for the deductible part of the self-employment tax and $1,010.00 in self-employed health insurance deductions. You further testified that you do not anticipate claiming any additional deductions in 2018.

10) Your application states, and you confirmed that you live in New York County.

11) You testified that you are seeking to be found eligible for advance payments of the premium tax credit.

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

APTC are generally available to a person who is eligible to enroll in a qualified health plan 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 qualified health plan, and (3) is not otherwise eligible for minimum essential coverage except through the individual market (*see* 45 CFR § 155.305(f), 26 CFR § 1.36B-2, 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 $12,060.00 for a one-person household (82 Federal Register 8831).

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 are available to a person who (1) is eligible to enroll in a qualified health plan 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 qualified health plan (45 CFR § 155.300(a), 45 CFR § 155.305(g)(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)).

"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)). Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (*id.*).

Legal Analysis

The first issue is whether NYSOH properly determined that you were ineligible for APTC, effective January 1, 2018.

You expect to file your 2018 income tax return as single and will not claim any dependents on that tax return. Therefore, you are in a one-person household.

On November 22, 2017, NYSOH validated your 2016 tax return as satisfactory documentation of your income and an application for financial assistance was run on your behalf by an NYSOH representative. The NYSOH representative entered into your application annual household income of $57,480.00, consisting of $61,980.00 you earn from your self-employment, $1.00 in taxable interest, and $709.00 in ordinary dividends, less deductions of $4,200.00 for the deductible part of the self-employment tax and $1,010.00 for the self-employment health insurance deduction.

NYSOH bases its eligibility determinations on modified adjusted gross income, which is adjusted gross income increased by any income that was excluded for United States citizens or residents living abroad, tax-exempt interest received or accrued, and Social Security benefits that were excluded from gross income. Adjusted gross income means gross federal taxable income minus certain specific deductions.

Your 2016 tax return, which the NYSOH representative allegedly relied on when entering the income amounts, shows that in 2016 you had income of $60,622.00 consisting of business income, taxable interest, ordinary dividends, and qualified dividends and deductions of $5,210.00, which results in adjusted gross income of $55,412.00.

Therefore, the November 22, 2017 application relied on incorrect annual expected income.

However, APTC is available to a person who meets the non-financial requirements and has a modified adjusted gross income that is between 200% and 400% of the FPL for the applicable family size. On the date of your application, the relevant FPL was $12,060.00 for a one-person household. Since an annual income of $55,412.00 is 459.47% of the 2017 FPL, you would have been ineligible for APTC based on the information you submitted if NYSOH had properly entered in the income information.

The second issue is whether you were properly found ineligible for cost-sharing reductions. Cost-sharing reductions are available to a person who is eligible for APTC and has a household income no greater than 250% of the FPL. Since a household income of $55,412.00 is 459.47% of the applicable FPL and you are ineligible for APTC, NYSOH correctly found you to be ineligible for cost sharing reductions.

As NYSOH properly found you eligible for a full cost qualified health plan, ineligible for APTC, and ineligible for cost-sharing reductions, the November 23, 2017 eligibility determination is AFFIRMED.

Decision

The November 23, 2017 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: February 20, 2018

How this Decision Affects Your Eligibility

You remain eligible to purchase a qualified health plan at full cost through NYSOH.

You are ineligible for APTC.

You are ineligible for cost-sharing reductions.

If You Disagree with this Decision (Appeal Rights)

If applicable, if you think a portion of your appeal should not be dismissed, you can ask us to vacate, or cancel, this dismissal. You must ask us in writing within 30 days after the date on this notice, showing good cause as to why the dismissal should be vacated. NYSOH's Appeals Unit will review your request. If your request is approved, another hearing will be scheduled for you. If your request is denied, NYSOH will tell you in writing. If you do not respond to the dismissed portion of your appeal within 30 days, your appeal will remain dismissed, and NYSOH will take no further action on your appeal.

Insofar as your case was decided, the 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 November 23, 2017 eligibility determination notice is AFFIRMED.

You remain eligible to purchase a qualified health plan at full cost through NYSOH.

You are ineligible for APTC.

You are 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.

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 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.

(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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