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

Notice of Decision

Decision Date: March 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025619

[redacted]

Dear [redacted]

On March 6, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's December 8, 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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STATE OF NEW YORK
DEPARTMENT OF HEALTH
P.O. Box 11729
Albany, NY 12211

Decision

Decision Date: March 13, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000025619

[redacted]

Issue

The issue presented for review by the Appeals Unit of NY State of Health is:

> Did NY State of Health (NYSOH) properly determine that you were eligible to receive up to $211.00 per month in advance payments of the premium tax credit (APTC)?

Procedural History

On December 7, 2017, you submitted an application for financial assistance through NYSOH.

On December 8, 2017, NYSOH issued an eligibility determination notice stating that you were eligible to receive up to $211.00 monthly in APTC, effective as of January 1, 2018.

On December 11, 2017, you spoke with NYSOH's Account Review Unit and requested an appeal relative to the amount of financial assistance you were determined eligible to receive.

On February 15, 2018, you had a scheduled telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. You stated that you were unable to participate in the hearing on that date, and your hearing was rescheduled for March 6, 2018.

On March 5, 2018, you uploaded additional documentation to your NYSOH account (*see* Documents [redacted]).

On March 6, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. Testimony was taken and the record was fully developed during the hearing. The record was 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 are appealing the amount of financial assistance you were determined eligible to receive.

2) According to your December 7, 2017, application, you attested to earned income of $43,800.00 and deductions of $6,300.00. Based on your attestation, your expected 2018 household income was calculated to be $37,500.00.

3) According to the December 7, 2017 application and your testimony, you expect to file a 2018 federal income tax return with the tax status of single and did not expect to claim any dependents on that tax return.

4) According to your NYSOH account, you reside in Kings County, New York.

5) On March 5, 2018, you submitted your 2017 Form 1098-E to NYSOH. Box 1 on the form reflects that $2,756.69 in student loan interest was received by the lender in 2017 (*see* Document [redacted]).

6) You testified that your expected 2018 household income, as stated in the December 7, 2017 application, did not include the amount that you expect to pay in student loan interest in 2018. Further, you expect the amount to be similar to the amount paid in 2017.

7) You testified that you also want your living expenses to considered when calculating your eligibility for financial assistance.

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)).

Subject to limitations, there shall be allowed as a deduction from the adjusted gross income, an amount not to exceed $2,500.00, equal to the interest paid by the taxpayer during the taxable year on any qualified education loan (26 USC § 221; IRS Publication 970 (2017)).

Living expenses, such as rent and utilities are not an allowable deduction in computing adjusted gross income (26 USC § 262(a)).

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 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).

For annual household income in the range of at least 300% but less than 400% of the 2017 FPL, the expected contribution is between 9.56% and 9.56% of the household income (26 CFR § 1.36B-3(g)(1), 45 CFR § 155.300(a), IRS Rev. Proc. 2017-36).

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).

<u>Affordability Exemption</u>

Under some circumstances, a person may receive an exemption from paying a penalty for not purchasing health insurance coverage. Such an exemption may be granted if that person can show that he or she experienced a financial hardship or has domestic circumstances that (1) caused an unexpected increase in essential expenses that prevented that person from obtaining health coverage under a QHP; (2) would have caused the person to experience serious deprivation of food, shelter, clothing, or other necessities, as a result of the expense of purchasing health coverage under a QHP; or (3) prevented that person from obtaining coverage under a QHP (45 CFR § 155.605(a), (g)).

NY State of Health has deferred to the U.S. Department of Health and Human Services (HHS) on the matter of hardship exemptions (see 45 CFR § 155.505(c)).

Legal Analysis

The issue under review is whether NYSOH properly determined that you were eligible for up to $211.00 of APTC per month.

Based on the application that was submitted on December 7, 2017, you attested to an expected annual household income of $37,500.00 and the December 8, 2017, eligibility determination relied upon that information.

You testified that you want your monthly living expenses to be considered when your financial assistance is determined. Since the Internal Revenue Service rules do not allow living expenses to be deducted from the calculation of your adjusted gross income, they cannot be deducted when the NYSOH computes your modified adjusted gross income for APTC purposes. Therefore, NYSOH correctly determined your household income to be $37,500.00.

The household for an individual, who expects to file a federal income tax return, 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 2018 federal income tax return, with the tax status of single, and do not expect to claim any dependents on that return. Therefore, you are in a one-person household for purposes of this analysis.

You reside in Kings County, New York, where the second lowest cost silver plan available for an individual through NYSOH costs $509.30 per month.

An annual income of $37,500.00 is 310.95% of the 2017 FPL for a one-person household. At 310.95% of the 2017 FPL, the expected contribution is 9.56% of the household income, or $298.75 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 ($509.30 per month) minus your expected contribution ($298.75 per month), which equals $210.55 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined you to be eligible for up to $211.00 per month in APTC.

The December 8, 2017 eligibility determination notice is AFFIRMED.

On March 5, 2018, you submitted your 2017 Form 1098-E to NYSOH. Box 1 on the form reflects that $2,756.69 in student loan interest was received by the lender in 2017 (*see* Document [redacted]). You testified that your expected 2018 household income did not include the amount that you expect to pay in student loan interest in 2018, and expect the amount to be similar to the amount paid in 2017.

A taxpayer may deduct from their adjusted gross income an amount equal to the interest paid during the taxable year on any qualified education loan, not to exceed $2,500.00. Based on the available record, your 2018 expected household income is ($37,500.00 - $2,500.00) $35,000.00.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, residing in Kings County, with an expected household income of $35,000.00.

Decision

The December 8, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, for an individual residing in Kings County, with an expected household income of $35,000.00, and to notify you accordingly.

Effective Date of this Decision: March 13, 2018

How this Decision Affects Your Eligibility

You were properly determined eligible for up to $211.00 monthly in APTC, effective as of January 1, 2018.

Your case has been returned to NYSOH to recalculate your eligibility for financial assistance based on the parameters above. NYSOH will notify you of its redetermination of your eligibility for financial assistance.

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 December 8, 2017 eligibility determination notice is AFFIRMED.

Your case is RETURNED to NYSOH to recalculate your eligibility for financial assistance based on a one-person household, for an individual residing in Kings County, with an expected household income of $35,000.00, and to notify you accordingly.

You were properly determined eligible for up to $211.00 monthly in APTC, effective as of January 1, 2018.

Your case has been returned to NYSOH to recalculate your eligibility for financial assistance based on the parameters above. NYSOH will notify you of its redetermination of your eligibility for financial assistance.

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.

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.

(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.

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).

(Yiddish) אידיש

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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