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

Notice of Decision

Decision Date: April 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026734

[redacted]

[redacted]

On March 12, 2018, you and your child appeared by telephone at a hearing on your appeal of NY State of Health's January 3, 2018 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: April 10, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000026734

[redacted]

Issues

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

> Did NY State of Health properly determine your child was eligible to receive up to $306.00 per month in advance payments of the premium tax credit, effective February 1, 2018?
>
> Did NY State of Health properly determine your child was eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine your child was not eligible for the Essential Plan?

Procedural History

On January 2, 2018, NY State of Health (NYSOH) received an updated application for financial assistance with health insurance submitted on behalf of your child.

On January 3, 2018, NYSOH issued an eligibility determination notice stating your child was eligible to receive up to $306.00 in advance payments of the premium tax credit (APTC), effective February 1, 2018. Your child was also eligible to receive cost-sharing reductions if he enrolled in a silver level qualified health plan. The notice indicated you child was not eligible for Medicaid or the Essential Plan, because the annual household income you provided was over the allowable income limits for those programs.

On January 3, 2018, you spoke to NYSOH's Account Review Unit and appealed insofar as your child was not eligible for the Essential Plan.

On March 12, 2018, 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 allow you time to submit supporting documents.

On March 14, 2018, March 25, 2018, and March 27, 2018, documents were uploaded to your NYSOH account. The documents were collectively incorporated into the record as Appellant's Exhibit #1 and the record closed thereafter.

Findings of Fact

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

1) You are seeking insurance for your child only.

2) According to your account, your child was [redacted] at all relevant times.

3) According to your account, your child was determined conditionally eligible for the Essential Plan multiple times in 2017 but his enrollments were subsequently terminated when NYSOH did not receive sufficient documentation of your household income to confirm his eligibility.

4) On January 2, 2018, NYSOH received another updated application submitted on behalf of your child. That application indicated you would file your 2018 tax return with a tax filing status of head of household and you would claim your one child as a dependent.

5) You testified that you claimed your child as a dependent on your 2017 tax return, but you were unsure whether you would claim him in 2018, because he was a student and would be graduating in 2018.

6) Your January 2, 2018 application listed your expected annual household income as $35,201.40 consisting of $9,461.40 you would earn annually from your part-time employment and $25,740.00 you would receive annually in Social Security disability payments of $2,145.00 monthly.

7) The application also indicated that your child had expected annual income from his part-time employment of $3,922.00. Your child's income was not included in the household income calculation.

8) The January 2, 2018 application indicated you would not take any deductions on your 2018 tax return. You testified that you would take a

deduction for tuition and fees, but you were unsure of the amount. You were advised to consult a tax professional and update your application with accurate information regarding deductions you intended to take.

9) Your application indicated that you and your child reside in Queens County.

10) NYSOH determined your child eligible to receive up to $306.00 in monthly APTC, effective February 1, 2018.

11) You appealed insofar as your child was not eligible for the Essential Plan.

12) Your child testified that he wants to have his own account through NYSOH, but has been unable to because he is a student and you claim him as a tax dependent.

13) Your child testified that he is a student and only works sporadically.

14) You testified that you had to take a part-time job to pay for expenses and that, as a result, your child's health insurance premium increased. You testified that you do not earn enough at your part-time job to pay for the increase in your child's health insurance premium.

15) You testified that you sometimes have to take unpaid time off of work due to [redacted].

16) You testified that due to various personal expenses owed by you and your child, you are unable to afford the premium for a qualified health plan for him.

17) You were directed to submit proof of income for you and your child.

18) On March 14, 2018 you uploaded paystubs from your employment.

19) On March 25, 2018 and March 27, 2018, NYSOH received letters from your child's former and current employers providing year to date income earned.

20) According to your account, NYSOH systematically redetermined your child's eligibility on March 26, 2018 and March 28, 2018, purportedly based on the income documentation submitted, and determined him eligible for $247.00 in monthly APTC and then $86.00 in monthly APTC, effective April 1, 2018.

21) Your account confirms that an updated application was submitted on behalf of your child on April 3, 2018 wherein your attested annual household income was reduced to $25,975.09.

22) According to your account, NYSOH redetermined your child's eligibility, based on the information in the April 3, 2018 application, and found him eligible for the Essential Plan with a $20.00 monthly premium, effective May 1, 2018.

23) Your account confirms your child was enrolled into an Essential Plan, effective May 1, 2018.

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 $16,240.00 for a two-person household (82 Federal Register 8831).

For annual household income in the range of at least 200% but less than 250% of the 2017 FPL, the expected contribution is between 6.34% and 8.10% 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).

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)).

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 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 2017 FPL, which is $16,240.00 for a two-person household (82 Fed. Reg. 8831).

A person who has a household income that is at or below 150% of the FPL has a $0.00 premium contribution (New York's Basic Health Plan Blueprint, p. 21, as approved January 2016; see https://www.medicaid.gov/basic-health-program/downloads/ny-blueprint.pdf).

A person who has a household income greater than 150% of the FPL or below 200% of the FPL has a $20.00 per month premium contribution (New York's Basic Health Plan Blueprint, as approved January 2016).

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)).

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 under review is whether NYSOH properly determined your child was eligible to receive up to $306.00 per month in APTC, effective February 1, 2018.

On January 2, 2018, NYSOH received an updated application for financial assistance with health insurance submitted on behalf of your child. That application indicated you would file your 2018 tax return with a tax filing status of head of household and you would claim your one child as a dependent. Although at the hearing you testified that you were unsure whether you would claim your child as a dependent on your 2018 tax return, the subject eligibility determination relied upon the information attested to in your application.

The application listed annual expected household income for 2018 of $35,201.40, consisting of $9,461.40 you would earn annually from your part-time employment and $25,740.00 you would receive annually in Social Security disability payments of $2,145.00 monthly. The eligibility determination at issue relied upon that information. It is noted that your application listed expected annual income for your child in the amount of $3,922.00, which was properly excluded from your household income calculation.

You testified that neither you nor your child can afford the premium for a qualified health plan, because you both have various personal expenses you are responsible for which should be considered when determining your child's eligibility for financial assistance with health insurance. However, since eligibility for financial assistance through NYSOH is based on an individual's modified adjusted gross household income as defined in the federal tax code, and Internal Revenue Service rules do not allow living expenses such as rent, utilities, cable, and phone to be deducted from the calculation of your adjusted gross income, they cannot be considered when NYSOH computes your modified adjusted gross income for APTC purposes. Thus, NYSOH properly based its eligibility determination on the $35,201.40 annual household income amount attested to in your application.

As discussed above, you and your child are deemed to be in a two-person tax household, because your application indicated you expect to file your 2018 income tax return as head of household and claim your child as a dependent. Thus, your income is included in his household income calculation.

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

An annual income of $35,201.40 is 216.75% of the 2017 FPL for a two-person household. At 216.75% of the FPL, the expected contribution to the cost of the health insurance premium is 6.93% of income, or $203.28 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 ($203.28 per month), which equals $306.02 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined your child eligible for up to $306.00 per month in APTC, based on the information in your application.

The second issue is whether your child properly determined 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 $35,201.40 is 216.75% of the applicable FPL, NYSOH correctly found your child eligible for cost-sharing reductions.

The third issue under review is whether NYSOH properly determined your child was ineligible for the Essential Plan.

The Essential Plan is generally 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 $16,240.00 for a two-person household. Since an annual household income of $35,201.40 is 216.75% of the 2017 FPL, NYSOH correctly found your child to be ineligible for the Essential Plan, based on the information in your application.

Therefore, the January 3, 2018 eligibility determination notice stating your child was eligible to receive up to $306.00 in monthly APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, was correct, based on your application, and is AFFIRMED.

It is noted that, following the hearing, you and your child submitted documentation of your income and NYSOH redetermined your child's eligibility, effective April 1, 2018, purportedly based upon that documentation. However, you subsequently submitted an updated application reducing your attested annual household income and, as a result, NYSOH has determined your child eligible for the Essential Plan, effective May 1, 2018. Based on the subsequent updated application and change in eligibility, the Appeals Unit will not return your case to NYSOH to redetermine your child's eligibility based upon the income documents submitted. It is further noted that this decision does not affect any subsequent eligibility determinations issued by NYSOH nor are any such determinations subject to the present review.

Decision

The January 3, 2018 eligibility determination notice is AFFIRMED.

Effective Date of this Decision: April 10, 2018

How this Decision Affects Your Eligibility

Your child was eligible to receive up to $306.00 in monthly APTC and eligible for cost-sharing reductions, based on the information in your January 2, 2018 application, effective February 1, 2018.

Your child was ineligible for the Essential Plan, based on the information in your January 2, 2018 application, effective February 1, 2018.

This decision does not affect subsequent eligibility determinations issued by NYSOH.

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 January 3, 2018 eligibility determination notice is AFFIRMED.

Your child was eligible to receive up to $306.00 in monthly APTC and eligible for cost-sharing reductions, based on the information in your January 2, 2018 application, effective February 1, 2018.

Your child was ineligible for the Essential Plan, based on the information in your January 2, 2018 application, effective February 1, 2018.

This decision does not affect subsequent eligibility determinations issued by NYSOH.

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 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.

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).