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

Notice of Decision

Decision Date: April 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027186

On March 20, 2018, you appeared by telephone at a hearing on your appeal of NY State of Health's January 13, 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 26, 2018

NY State of Health Account ID: [redacted]
Appeal Identification Number: AP000000027186

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, your spouse, and your adult child were eligible to share in an advance payment of the premium tax credit of up to $1,162.00 per month and cost-sharing reductions, as of February 1, 2018?
>
> Did NY State of Health properly determine that you, your spouse, and your adult child were eligible for cost-sharing reductions?
>
> Did NY State of Health properly determine that you, your spouse, and your adult child were not eligible for the Essential Plan?

Procedural History

On January 12, 2018, you updated your, your spouse's, and your adult child's (family) application for health insurance. That day a preliminary eligibility determination was issued stating that your family was eligible to share in an advance payment of the premium tax credit (APTC) of up to $1,162.00 per month and cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective February 1, 2018.

Also on January 12, 2018, you contacted NY State of Health's (NYSOH) Account Review Unit and requested an appeal of the preliminary eligibility determination as it related to your family's eligibility for additional financial assistance.

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 January 13, 2018, NYSOH issued an eligibility determination notice, consistent with the preliminary eligibility determination, stating that your family was eligible to share in an APTC of up to $1,162.00 per month and cost-sharing reductions if you enrolled in a silver-level qualified health plan, effective February 1, 2018. The notice stated that your family was not eligible for the Essential Plan because your household income was over the allowable limit for that program.

On March 20, 2018, you had a telephone hearing with a Hearing Officer from NYSOH's Appeals Unit. The record was held open to April 18, 2018, for you to submit proof of your current income for the 2018 tax year. As of the close of business on April 18, 2018, the Appeals Unit did not receive any of these documents from you nor were they visible in your NYSOH account. Therefore, the record was closed that day and this Decision is based on the record as developed at the time of hearing.

Findings of Fact

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

1) According to your NYSOH account, you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim your adult child as a dependent on that tax return. You testified this is incorrect and that you plan on claiming your other child as a dependent (not the one listed in your application).

2) You are seeking health insurance for your family.

3) The application that was submitted on January 12, 2018, listed annual household income of $48,359.89, consisting of $17,400.00 in earnings you receive from your employment, and $30,959.89 your spouse receives from his employment. You testified this was incorrect. You testified you received $24,331.00 in employment income in 2017 and this amount should be the same in 2018.

4) According to your application, you will not be taking any deductions on your 2017 tax return. You testified this is not correct. Your spouse is paying student loan interest and tuition and fees that you believe should be considered.

5) You failed to submit proof of your current income, dependents, and deductions.

6) According to your NYSOH account and testimony, your family lives in [redacted], NY.

7) You testified that you have bills including a home equity line of credit that you think should be deducted from your household income

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

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 $ 20,420.00 for a three-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 in 2018 is between *6.34*% and 8.1% 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 $ 20,420.00 for a three-person household (82 Federal Register 8831).

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 determined that you family was eligible to share in an advance payment of the premium tax credit of up to $1,162.00 per month and cost-sharing reductions, as of February 1, 2018?

The application that was submitted on January 12, 2018, listed an annual household income of $48,359.89 and the eligibility determination relied upon that information.

However, during the hearing you testified that although your gross annual household income is higher than the $48,359.89 as attested to in the January 12, 2018 application, you plan on claiming your other child as a dependent (not the one listed in your application) and your spouse has student loan interest and tuition expenses you believe should be considered. Consequently, the record was kept open to April 18, 2018, to allow you time to submit proof of your current income, your dependents, and your deductions. You did not submit this proof and, therefore, this decision is based on the evidence in the record.

Additionally, you testified that you have bills, including a home equity line of credit, that you think should be deducted from your household income.

Since the Internal Revenue Service rules do not allow living expenses such as a mortgage payment, home equity line of credit, utilities, cable, and phone 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 properly determined your household income to be $48,359.89, based on the income information you provided.

According to your NYSOH account, you expect to file your 2017 taxes with a tax filing status of married filing jointly. You will claim one dependent on that tax return. Therefore, for purposes of these analyses, your family is in a three-person household.

Your family resides in Rockland County, where the second lowest cost silver plan available for a family through NYSOH costs $1,469.78 per month.

An annual income of $48,359.89 is 236.83% of the 2017 FPL for a three-person household. At 236.83% of the FPL, the expected contribution to the cost of the health insurance premium is 7.64% of income, or $307.89 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 a family in your county ($1,469.78 per month) minus your expected contribution ($307.89 per month), which equals $1,161.90 per month. Therefore, rounding to the nearest dollar, NYSOH correctly determined your family to be eligible to share in up to $1,162.00 per month in APTC, based on the information you provided.

The second issue under review is whether your family was 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 $48,359.89 is 236.83% of the applicable FPL, NYSOH correctly found your family to be eligible for cost sharing reductions, based on the information you provided.

The third issue under review is whether NYSOH properly your family 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 $20,420.00 for a three-person household. Since an annual household income of $48,359.89 is 236.83% of the 2017 FPL, NYSOH correctly found your family to be ineligible for the Essential Plan, based on the information you provided.

Since the January 13, 2018 eligibility determination notice properly stated that, based on the information you provided, your family was eligible for up to $1,162.00 per month in APTC, eligible for cost-sharing reductions, and ineligible for the Essential Plan, it is correct and is AFFIRMED.

Decision

The January 13, 2018 eligibility determination notice is AFFIRMED.

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 Decision has no effect on any eligibility redeterminations made or notices issued by NYSOH.

Effective Date of this Decision: April 26, 2018

How this Decision Affects Your Eligibility

Your family was properly determined eligible for up to $1,162.00 per month in APTC, as of February 1, 2018.

Your family was properly determined eligible for cost-sharing reductions.

Your family was 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 January 13, 2018 eligibility determination notice is AFFIRMED.

This Decision has no effect on any eligibility redeterminations made or notices issued by NYSOH.

Your family was properly determined eligible for up to $1,162.00 per month in APTC, as of February 1, 2018.

Your family was properly determined eligible for cost-sharing reductions.

Your family was properly determined ineligible for the Essential Plan.

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.

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 کرم 1-855-355-5777 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)**

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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).